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ABSTRACT

This document is comprised of the six 2001 issues of a bimonthly newsletter providing information on young children's health and safety for California's child care professionals. Regular features include a column on infant/toddler concerns, a question-answer column regarding medical and health issues, and resources for child care providers. Periodically featured is information on behavioral and school-age care issues. The feature articles for each issue are as follows: (1) "Including All Children in San Diego" (Jan-Feb); (2) "Hooray for Health Consultants and Health Coordinators!" (Mar-Apr); (3) "CCHP [California Childcare Health Program] Welcomes New Staff" (May-Jun); (4) "Injuries in Child Care Centers: Gender-Environment Interactions" (Jul-Aug); (5) "Talking with Parents about Better Compensation for Child Care Staff" (Sep-Oct); and (6) "Caring for Ourselves" (Nov-Dec). (KB)

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Child Care Health Connections, 2001: A Health and Safety Newsletter for California Child Care Professionals

Nancy Walery, Sara Evinger, Lyn Dailey, Rahman Zamani, and Eva Guralnick, Editors

Volume 14, Numbers 1-6, January-December 2001

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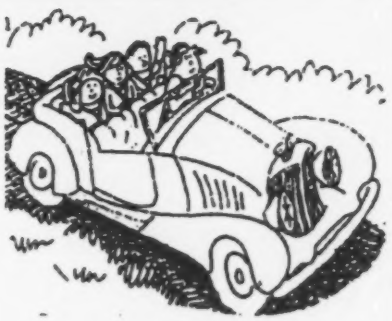
Child Care Health Connections©2001

A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

January-February 2001 **Volume 14, No. 1**



New CCHP Child Passenger Safety Project

***Safely on the Move* is here to:**

- Answer your questions about child passenger safety
- Discuss how to drive children around safely
- Learn how you are driving children around safely
- Talk about changes in the child restraint law
- Provide information and resources for child care providers and families
- Link you with child passenger safety experts in your local community

Safely on the Move can be reached through the Healthline at (800) 333-3212 or at the administrative offices at (619) 594-4373. ❖

Including all children in San Diego

FAMILIES who have children with special needs struggle to find and maintain appropriate high-quality child care. California's Map to Inclusive Child Care ("Map") Project of the California Child Care Health Program identified a number of barriers for both families and child care providers to include children with disabilities and other special needs in child care. The California Children and Families Commission (Prop 10) is currently funding an in-depth study by the WestEd Center for Prevention and Early Intervention that will develop a county-level analysis of barriers, services and supports. While statewide efforts can effect some change in policy and practice, county or local efforts are more directly affecting families and children. The California Child Care Health Program applauds San Diego's proactive efforts to improve the lives of children with special needs and their families.

by Betty Z. Bassoff, DSW

The San Diego County Child Care Planning and Development Council commissioned a study in May 2000 to determine to what extent children with special needs are currently included in community-based child care programs. The study used two approaches to get information: 1) a survey of centers and family child care homes, and 2) focus group meetings with parents who have children with a variety of special needs. The findings are important in promoting and supporting inclusion activities across the child care field.

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Child Care Health Connections

January-February 2001
Volume 14, No. 1

Child Care Health Connections *is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.*

Six issues of ***Child Care Health Connections*** *are published during the year in odd-numbered months at the subscription rate of $20 per year.*

Newsletter articles may be reprinted *without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.*

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Information provided in ***Child Care Health Connections*** *is intended to supplement, not replace, medical advice.*

Visit us on the Web:
www.childcarehealth.org

Ask the nurse . . .

by Terry Holybee, RN

Q *I noticed that one of my 4-year-olds went for his booster shots and, instead of the OPV being checked on the yellow card, IPV was checked. What is IPV?*

A What a great observation! Many child care providers will be seeing IPV on the immunization records from now on. IPV is Inactivated Polio Vaccine. Until recently OPV (Oral Polio Virus) was recommended for most children in the United States. OPV has helped us rid the country of polio and is still used in many parts of the world.

Both vaccines give immunity to polio, but OPV is better at keeping the disease from spreading to other people. However, for a few people (about one in 2.4 million), OPV actually causes polio. Since the risk of getting polio in the U.S. is now extremely low, experts believe that using oral polio vaccine is no longer worth the slight risk, except in limited circumstances. The inactivated polio vaccine does not cause polio.

IPV is a shot, given in the leg or arm depending on age. It may be given at the same time as other vaccines—at 2 months, 4 months, 6-18 months, and a booster dose between 4 and 6 years of age.

Other vaccine news

A new vaccine, *pneumococcal conjugate*, is licensed for infants and toddlers and may be showing up on the yellow cards soon. It is good at preventing pneumococcal disease among young children and also helps stop the disease spreading from person to person. The vaccine is given along with the other childhood vaccines at the ages of 2 months, 4 months, 6 months, and between 12 and15 months.

Pneumococcus is a bacteria which can cause pneumonia and sometimes meningitis. It is responsible for about 200 deaths each year among children under 5 years of age. In the United States, pneumococus is the leading cause of bacterial meningitis, an infection of the covering of the brain. Each year pneumococcal disease causes over 700 cases of meningitis, 17,000 blood infections and about 5 million ear infections.

If you have any questions regarding these or other immunizations, contact the Immunization Branch, California Dept. of Health Services at (510) 540-2065; or the Healthline at (800) 333-3212. ❖

Adapted from the Vaccine Information Sheets developed by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Immunization Program.

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Infant/toddler care

Diapering is not just routine

by Cheryl Oku, Infant/Toddler Specialist

Changing a baby's diaper is an opportunity for the child to learn and bond with you, and a time to take important precautions for the protection of the child's and your own health. Diapering can be a special time for the caregiver and baby to have full attention in a one-on-one situation. It is an important learning activity for the child, who is engaged and participating at his own level of ability. Caregivers who talk with and encourage the child's participation support feelings of competence and facilitate language development.

The diapering area

A well-planned diapering area is basic to healthy, safe and easy diapering. These are some important rules to remember:

- Use the area only for diapering.
- Set up the diapering area as far as possible from any food handling area.
- Provide running water for handwashing immediately after diaper changes.
- Construct a flat and safe diapering surface high enough to prevent stress on your back.
- Be sure the surface is clean, waterproof and free of cracks or crevices.
- Cover the surface with a disposable cover, such as paper bags, used computer paper or rolls of paper.
- Keep all creams, lotions and cleaning items out of children's reach, but within yours.
- Add a guard rail at least three inches high for extra safety.
- Always keep a hand on the child.
- Never leave the child unattended, even for a second.
- Provide safe steps to allow older children to climb up on to the table.

Sanitation

- Most experts do not recommend the routine use of latex gloves for diapering (unless blood is present). If you do use gloves, be sure to follow recommendations for using gloves effectively.
- Be sure to wash the child's hands and your own with soap under running water (infants, too).
- Clean and disinfect the diapering area and all equipment and supplies that were touched.
- The steps to hygienic diapering can be obtained by calling the Healthline.

Social and learning opportunities

Remember these principles and make diapering a bonding time for you and the child:

(continued on page 11)

Child care health and safety performance standards

by Gail Gonzalez, RN

Published in 1992, the *National Health and Safety Performance Standards, Guidelines for Out-of-Home Child Care Programs*, were written to address the needs of children and families when they are involved in programs outside of their own homes. The standards are published under the name *Caring For Our Children.*

The standards address all forms of out-of-home care for children: centers, after-school care, infant care, family child care homes and recreation programs. It does not matter whether the program is in a house, office park, a church or a recreation hall. Funding is not a consideration, nor is licensing or supporting agencies. The standards were developed to prevent illness and injury in young children who are expected to congregate in groups for the purpose of play, work and socialization. All child care programs striving for quality will want to meet the standards set forth in this document, recognizing the unique atmosphere within a child care program.

I am reminded of the differences between school and child care. In school, the children are expected to work at a desk or in a small group and interact with a larger group primarily when out of doors. The objective of the day is to have children focus on a learning task until individual understanding is gained. In child care, most of the day is spent on the floor or in play groups that are very intimate, encouraging group experience and cooperation. Even when the child care program is housed within a school facility, the health and safety needs are different than those of the classroom that previously occupied that space.

(continued on page 11)

Hidden infections in child care

by Lyn Dailey, PHN

Viral and bacterial infections are an expected part of early childhood and therefore an inevitable part of child care. Young children entering or changing child care will certainly experience episodes of illness. Colds, flu and diarrhea are by no means "hidden" infections. We see the obvious signs and symptoms, but what happens when infections aren't so obvious?

The Healthline recently consulted on a case in which a parent voluntarily told a potential caregiver that his child had CMV (cytomegalovirus). The caregiver refused to enroll the child for fear of exposing other children and staff to the infection. This example highlights one of the common misunderstandings about the spread of communicable disease.

CMV is a very common infection that may or may not have mild, flu-like symptoms. The virus is spread through contact with the urine, blood or saliva of an infected person. The virus can be shed in these bodily fluids for months or years after recovering from the illness. CMV is especially dangerous for people with weakened immune systems or for the unborn babies of pregnant women who become infected for the first time during their pregnancy.

- Parents are not required to tell caregivers if their child has this type of infection.
- People can be infected with CMV and not know it. There may not be any signs or symptoms of infection.
- Most adults have been infected with CMV at some time in their life. Most children will have contracted CMV by the time they start school. Assume all children are shedding this virus.

In this case, a caregiver was afraid to enroll a child because she knew of his CMV infection. What about the other children already enrolled? There are likely to be many children in the program who are, were, or will be shedding the virus at some time. There may also be other hidden infections (such as hepatitis A and B, or HIV) the parents and caregiver are not aware of. To provide the highest possible level of protection to staff, parents and children, *practice universal precautions at all times*. The proper use of gloves when handling bodily fluids containing blood, frequent handwashing and up-to-date immunizations (for hepatitis A and B; there is no vaccine for CMV or HIV) are part of universal precautions. Caregivers who are pregnant or might become pregnant should speak with their medical provider about their occupational risks. ❖

California gets low marks for oral health

by Rahman Zamani, Program Analyst

According to a national report card by Oral Health America, California gets a "C-minus". The Fall 2000 report, released on October 10, supports the earlier findings of the Surgeon General's report describing oral health in America as a "silent epidemic" of oral disease. A grade from A to F was given to each state based on its level of achievement in oral health. Despite great variation among the states, all 50 states and the District of Columbia scored poorly in the three broad categories of prevention, access to oral health care and oral health status.

Based on data largely collected from the Centers for Disease Control and Prevention, the National Institute of Dental and Craniofacial Research, and state dental directors, the report gives California a C-minus for prevention (with its lowest grade on fluoridation of the public water supply, and only 14-38 percent use of sealants for preventing cavities especially in young people); C-minus for access to dental care; and B-minus for health status.

This report card points to the critical importance of improving oral health and concludes that "oral health is the gateway to overall health" and "failure to [improve it] will result in serious, long-term health consequences to our nation, especially our children."

Tooth decay is the single most common chronic childhood disease—five times more common than asthma and seven times more than hay fever. Thirty to 40 percent of 3-year-old children have at least one cavity.

(continued on page 10)

Parent Page

Allergies

by Terry Holybee, RN

Children with allergies can pose challenges for parents and child care providers alike. Allergies are the most frequent chronic disease found in child care. Identifying the substance that makes your child sneeze, wheeze or itch can be difficult and trying. Many parents have learned to keep food and environmental diaries to help pinpoint the allergen (substance that causes allergy) for their children.

The Food Allergy Network reports that between 2 to 2½ percent of the general population suffers from food allergies. That means 6-7 million Americans suffer some type of reaction to the foods they eat. Eight foods account for the majority of these allergic reactions: peanuts, tree nuts (walnuts, pecans, etc.), fish, shellfish, eggs, milk, soy and wheat. Peanuts are the leading cause of severe allergic reactions, followed by shellfish, fish, tree nuts and eggs. Other allergens include insects (bees, wasps), pollens (from plants) and animals (cats, horses, dogs, etc.).

During an allergic reaction, the immune system releases large amounts of chemicals such as histamines to protect the body from the offending allergic substance. These chemicals trigger a chain of allergic symptoms that can affect the respiratory system, gastrointestinal tract (involving the stomach or intestines), skin or cardiovascular system (involving the heart and blood vessels). Symptoms can include a tingling sensation in the mouth, swelling of the throat and tongue, difficulty breathing, hives, vomiting, abdominal cramps, diarrhea and a drop in blood pressure. Symptoms typically occur within minutes to two hours after the person has eaten the food to which he is allergic. A serious, often life-threatening allergic reaction characterized by low blood pressure, shock and difficulty breathing is called an *anaphylactic reaction*.

While avoidance is the most important aspect in the management of life-threatening allergies, medical treatment needs to be immediate. The treatment of choice is epinephrine, administered by injection. Other medications such as antihistamines, asthma medications or steroids may be given, but only as a second line of defense. Consult with your health care provider about a prescription for an epinephrine administration kit (usually Epi-Pen Jr. for children). These kits deliver a pre-mixed epinephrine solution through a shot that anyone can administer. The use of Epi-Pen is considered life-saving first aid and not prohibited in child care. Kits should be taken to your child care program where the child may be exposed to allergens. Check the expiration date periodically on each kit to make sure the contents have not expired.

Your child care provider should receive training from you or your health care provider about your child's specific allergies. The training should include the following:

- What is your child allergic to?
- What symptoms does your child typically have?
- What is the treatment of choice for your child?
- How will the child care provider contact you in an emergency?
- What are the side effects of the treatment of choice?
- What are possible adverse/negative effects of the treatment of choice?
- Practice with a demonstration Epi-Pen Jr. that does not contain medication.
- If an injection of epinephrine is necessary, the child care provider should call 911 to have your child transported to the hospital. *Under no circumstances should the child care provider attempt to drive your child to the hospital.*

Developing a plan of action with your child care provider can be a critical factor in saving your child's life. Ask for your provider's cooperation and support in reducing or eliminating potential allergens from the child care home or center. With specific allergies such as peanut allergies, total elimination of peanuts and peanut products is recommended. Call the Healthline for suggestions of healthy and appetizing substitute foods. Ensure that the provider is trained in recognizing the signs of an impending anaphylactic attack and knows how to care for your child after administering epinephrine. By working together, your child's experience in child care can be a safe and healthy one. ❖

Source: The Food Allergy Network. (800) 929-4040 or www.foodallergy.org

HEALTH & SAFETY NOTES

California Child Care Health Program

IS IT SAFE TO PLAY OUTDOORS IN WINTER?

➢ ***Fresh air is healthy***. Studies have shown that contrary to the common belief that "exposure to cold air causes a cold," fresh air is good and healthy. When children and adults spend a long time together in indoor spaces that are small, overheated and poorly ventilated, germs and illnesses pass easily from one person to another. In fresh, outdoor air, children do not have to rebreathe the germs of the group, and the chance for spreading infection is reduced.

➢ ***Outdoor play is healthy even in winter***. Children of all ages enjoy and benefit from playing outdoors in all except the most extreme weather. Daily outdoor play is healthy and burns energy. It gives children an opportunity for a change of environment, a balance in play and routine, activities of large muscles (gross-motor development). Even children who are mildly ill but active should go outside if the weather is not severe. Staff and children alike will feel refreshed when fresh air is part of the daily routine. Taking children outdoors daily, even in winter, can be a healthy part of their schedule, and is safe when clothing is appropriate.

➢ ***Avoid cold-related injuries***. The way we feel about cold, wet, or snowy weather and indoor temperatures may be affected by where we live and what we are used to. Temperatures above 40 and below 80 degrees Fahrenheit are generally suitable for routine outdoor play.

➢ ***Improve indoor air quality***. Germs causing disease multiply in warm, dark, damp environments, so it is important to keep the environment clean and dry.

Adequate ventilation, humidity, and temperature control help us resist illness and increase our ability to get well after sickness.

The following measures will improve the indoor air quality in your child care setting:

- Keep the air temperature between 65° and 75° Fahrenheit, if possible.
- Open the windows in every room for a few minutes every day to circulate fresh air, even in winter. Windows must be screened to prevent insects from entering, and should be opened no more than 6 inches (or be protected with guards) to prevent children from falling out.
- Do not allow smoking in any space that children will use.
- Properly vent heating and cooking equipment.
- Avoid strong odors. Some people (including children) are allergic to smoke, perfumes, and room deodorants.
- Reduce the use of toxic pesticides and cleaners and other household chemicals.
- Control dampness and dust.
- Colds, sore throats and other infections of the respiratory system are common in cold weather and are usually caused by viruses. Child care providers have the potential to improve the health of children in their care by opening up windows to improve ventilation, and having children play for extended periods outdoors in the fresh air. They can provide instruction and programs that promote enjoyable, lifelong physical activity.

Remember

Handwashing is the single most effective way to reduce the spread of infection in a child care setting.

Resources: *Keeping Kids Healthy: Preventing and Managing Communicable Disease in Child Care*, California Department of Education, 1994; *Healthy Young Children: a Manual for Programs*, NAEYC, 1995; *The Lancet*, Volume 349, Number 9062, May 10, 1997; *Well Beings*, the Canadian Paediatric Society, Volume 1, 1992.

By Rahman Zamani, MPH (8/25/98)

HEALTH & SAFETY NOTES

California Child Care Health Program

CYTOMEGALOVIRUS (CMV) IN THE CHILD CARE SETTING

➢ ***What Is It?*** CMV is a very common infection caused by a virus with which most people eventually become infected. Children and staff in the child care setting are especially likely to be infected.

➢ ***What Are the Symptoms?*** Children usually have no symptoms when they become infected with CMV. Occasionally, older children in child care will develop an illness with a fever, sore throat, swollen glands (lymph nodes) in the neck, enlarged liver, rash, and being tired. However these symptoms are very rare, especially in young children in child care.

CMV can be dangerous for people with immune problems, and pregnant women who can spread the illness to their unborn babies.

➢ ***How Is It Spread?*** CMV is spread from person to person by direct contact with bodily (body) fluids such as blood, urine, or saliva. Thus it may be spread through close contact such as in diaper changing, kissing, feeding, bathing, and other activities where a healthy person comes in contact with the urine or saliva of an infected person. CMV can also be passed from a mother to the child before birth, at birth and after birth (through breastfeeding).

➢ ***When Is It Contagious?*** Some people infected with CMV are contagious for a very short time; others can spread the virus for months to years.

➢ ***Should the Child Stay Home?*** There is no reason to exclude the child from child care because the program probably has other children who have CMV.

➢ ***Is It a Problem for Pregnant Women?*** If infected for the first time during pregnancy, women are at a small risk of delivering an infant with CMV disease, which can cause hearing loss, mental retardation and other birth defects.

➢ ***Female child care providers who expect to become pregnant should:***

- Be tested for antibodies to CMV. If the test shows no evidence of previous CMV infection, reduce contact with infected children by working, at least temporarily, with children age 2 years or older, where there is far less virus circulation.
- Wash hands with water and soap after each diaper change and contact with children's saliva.
- Avoid contact with children's saliva by not kissing children on the lips and ask them not to place hands, fingers, toys and other saliva-contaminated (soiled) objects in their mouth.

Remember

Contact with children which does not involve exposure to saliva or urine poses no risk to a mother or child care provider and should not be avoided out of fear of potential infection with CMV.

➢ ***How Can You Limit the Spread?***

- Follow Universal Precautions for the child care setting (see Health & Safety Note: "Universal Precautions in the Child Care Setting").
- Clean and disinfect all mouthed toys and frequently used surfaces on a daily basis.
- Don't kiss children on the mouth.
- Do not share food, pacifiers, bottles, toothbrushes, eating utensils or drinking cups.

Female staff who are pregnant or thinking about getting pregnant should discuss the issue with their health care provider.

Resources: *Red Book 2000*: Report of the Committee on Infectious Disease, American Academy of Pediatrics, 2000; *The ABCs of Safe and Healthy Child Care: A Handbook for Child Care Providers*, Centers for Diseases Control and Prevention (CDC), 1997; *Healthy Young Children: a Manual for Programs*, NAEYC, 1995 Edition; *Caring for Our Children: National Health and Safety Performance Standards*, Guidelines for Out-Of-Home Child Care Programs, Washington DC, AAP & APHA, 1992.

By Rahman Zamani, MPH (11/14/00)

Don't skip a step with child passenger safety

by Sara B. Woo, MPH, Project Coordinator, Safely on the Move

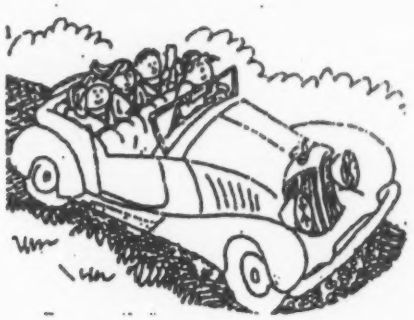
Buckle up and celebrate National Child Passenger Safety week from Feb. 11-17, 2001. National Child Passenger Safety week, along with other campaigns such as Buckle Up America and Boost America, emphasize the importance of properly buckling up children. Traffic crashes remain a leading cause of injury and death to young children. Ensure that children in your care are riding the safest possible way, whether riding to and from child care or on field trips.

As children progress through different stages of growth and development, their child restraint needs change. Infants ride rear-facing in an infant or convertible seat as long as possible but at least until they weigh 20 pounds *and* are 1 year of age. For toddlers and preschoolers, use a child restraint with a harness until the child outgrows it. The preschool or school-age child graduates to a belt-positioning booster to raise them up and improve the fit of the vehicle shoulder and lap belt. A shield booster, which has a bolster in front of the child and no back, is not certified for children over 40 pounds and not recommended for children under 40 pounds.

As of Jan. 1, 2002, California law will require children to ride in a child safety seat until they are at least 6 years old or weigh 60 pounds. Children prematurely riding in a seat belt can suffer life-threatening injuries, including injury to the spinal cord, the brain or the internal organs of the abdomen. Most children need to use a belt-positioning booster seat until they are at least 8 years old, depending on the child's height and how the vehicle lap and shoulder belts fit. Safety belts don't fit children properly until they can sit with their backs straight against the vehicle seat back cushion and their knees bent over the seat edge for the entire trip. The lap belt should fit low and snugly across the child's upper thighs and the shoulder belt should cross the shoulder, not the throat or face, and be close to the child's chest.

See the March/April newsletter for suggestions on developing a safe transportation policy or contact Sara Woo through the Healthline at (800) 333-3212 or directly at (619) 594 4373. ❖

Sources: *The Danger of Premature Graduation to Seat Belts for Young Children*, by FK Winston, DR Durbin, MJ Kallan, EK Moll. Pediatrics V.105(6): 1179-1183; June, 2000.



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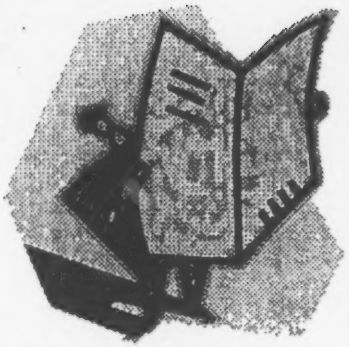
UNIQUE NEEDS OF BIRACIAL/BIETHNIC CHILDREN

- Processing more than one ethnic and racial identity
- Biases and assumptions from peers and community
- Possible lack of support from family and community
- May not be prepared for racism, or how the wider society views them compared to how they view themselves
- Feeling pressure to choose one identity
- Ability to travel in more than one culture
- Change identity depending on developmental stage
- If the child is adopted, and neither parent is the child's race or ethnicity, then consider all of the above in addition to typical issues regarding adoption.

Source: *Serving Children from Biracial/Bi-ethnic Families: A Supplementary Diversity Training Curriculum for Child Care Providers.*

Including all children *(continued from page 1)*



The survey asked providers to identify those children in their care over the past year who have significant needs in eight categories. Child care providers' responses showed that about 6.5 percent of the children in child care have significant special needs using the federal Maternal and Child Health Bureau definition:

> *"Children who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who require health and related services of a type or amount beyond that required by children generally."*

National statistics on prevalence of disability range from 10 to 20 percent of children ages birth to 17 years. The National Health Interview Survey on Disability, conducted in 1994-95, used a broad definition similar to that of the Maternal and Child Health Bureau and found 18 percent of the families surveyed had children with a special health need or disability.

The San Diego County child care providers' survey responses showed that about 6.5 percent of the children in child care have significant special needs using the federal Maternal and Child Health Bureau definition.

In addition to the San Diego survey, five focus groups were conducted with families who have children with special needs throughout San Diego County. Parents were almost unanimous in their experience of obstacles to obtaining child care. They cited denials, accommodations that had to be made by the parent, inappropriate placement and child-staff ratios in before- and after-school care that prevented inclusion.

Child care providers and parents agreed on the following important strategies for expanding child care opportunities for children with special needs:

- Supplementary funds to raise the teacher/provider-to-child ratios by hiring assistants as needed or by enrolling fewer children; and
- Training and mentoring of staff, both on accommodations which can be made at relatively little cost and on child-specific needs.

A number of action steps were recommended and adopted by the San Diego Child Care Planning and Development Council. The Council recognized that child care providers in San Diego County are currently serving fewer children with special needs (6.5 percent) compared to the general population (10 to 20 percent) and agreed to support an increase in the number of children with special needs in child care to 12 percent over the next five years. This means that San Diego County will be exploring methods and strategies for improving funding and support for children with special needs and their families.

For a copy of the full report, please contact Kathy Anderson, Council staff at (619) 515-6906 or e-mail her at kanderss@co.san-diego.ca.us. For information on taking action in your community and for help with specific inclusion efforts, call the Healthline. ❖

Inclusion insights

Developmental risk and birth defects

by Pamm Shaw and Sandra Zehaye, Disability Specialists

In the early 1960s, the March of Dimes began funding research to unveil the many health and developmental risks to newborns based on the knowledge of that time. Since then, continued research has informed the policies and practices of intervention for health professionals, social workers, early childhood and special educators, therapists, families and the community at large. This research has shown the importance of maternal health and nutrition, and the need for pre- and post-natal health care.

Current research has confirmed that developmental risk can caused by the environment, genetics and poor nutrition on the developing brain. Environmental risk can include the conditions where the parent lives or where the embryo lives *in utero*. Perinatal use of tobacco, drugs and alcohol can cause harm to the unborn child. Genetic traits passed down through families can also increase the risk for certain diseases such as alcoholism or diabetes and result in birth defects through chromosomal and genetic disorders.

The health and nutritional status of the mother before she becomes pregnant are significant to the outcome of a healthy pregnancy. Even her level of stress and response to day-to-day routines can affect the unborn child's health. When babies are born prematurely or with compounding medical or environmental risks, technological advances have significantly increased the chances of survival. Babies as small as one

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Provider Health

Caring for ourselves

by Judith Kunitz, MA, Child Development Specialist

As caregivers, we often overlook our own health needs to tend to the children in our care. But our well-being is paramount if we are to be positive role models and provide quality care. Exercise, relaxation and good nutrition can rejuvenate us and help balance our hectic daily lives.

Getting started with exercise

- Make exercise a regular and integral part of your life. (Caring for children is not exercise, just hard work.)
- Start slowly to avoid strain. Check with your health care provider if you have health concerns.
- Find the type of exercise you enjoy. Experiment and try out different types of classes or programs.
- Try to exercise for 20 to 30 minutes at least three times a week.
- Take a walk or bike ride. Enjoy the passing scenery.
- Use the stairs instead of the elevator.
- Park a few blocks from your destination and walk the final distance.
- Find exercise classes at your local YMCA, fitness center, health club, community center or adult school.
- Ask friends where they take exercise classes. Go along for an introductory class.

Taking the time to relax

- Be sure to take the breaks you are entitled to while you work (15 minutes every four hours) and at least a 30-minute lunch break.
- Find a quiet, safe place to sit or lay down. A few deep breaths can help release tension. Try to empty your head of busy thoughts.
- Take a leisurely walk. Ten minutes of exercise can ease stress.
- Relax with music, movies, reading or talking with a friend.
- Take a hot bubble bath or shower.
- Soak your feet in warm water, then in cold.
- Search out a yoga or meditation class.
- Write a letter to a friend or family member. Keep a journal.
- Sit and allow yourself to daydream.

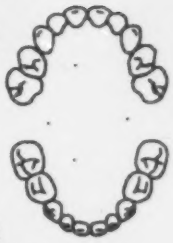
Eating for better health

- Attempt to sit and eat meals with the children rather than stand and gulp your food. Model good eating habits.
- Follow the same food preparation standards used for the children in your care when preparing your own meals.
- Avoid junk food, and add more fruits and vegetables to your diet.
- Attempt to drink up to eight glasses of water throughout your day. ❖

Adapted in part from *Child Care Provider's Guide to Health and Wellness*, YMCA Childcare Resource Service, San Diego County.

Oral Health

(continued from page 4)



Tooth decay and gum disease are the most common oral health problems, and yet both are preventable.

Child care providers can play an important role in promoting the oral health of young children. You can educate families about the importance of good oral health, and improve and protect the dental well-being of children in your care by:

- Recognizing the importance of a "dental home" (similar to a medical home) and promoting the concept to parents;
- Establishing a relationship with a Pediatric Dental Health Consultant;
- Paying attention to snack quality and quantity;
- Being prepared to handle dental emergencies;
- Using fluoride;
- Cleaning teeth and gums; and
- Preventing baby bottle tooth decay by not giving children bottles to help them go to sleep.

For information on resources that could help cover children's dental care expenses, refer to our September-October 2000 issue of CCHC, visit our Web site at www.childcarehealth.org, or call the Healthline. ❖

Got questions? Call the Healthline at (800) 333-3212.

Diapering *(continued from page 3)*

- Focus your attention on the child.
- Treat the child with respect.
- Talk with the child about what you are doing and what the child is experiencing. ❖

Sources: *Health and Safety in the Child Care Setting: Prevention of Infectious Disease*, The California Child Care Health Program Guide to Routines, Program for Infant/Toddler Caregivers, WestEd and the California Department of Education

The Infant-Toddler Specialist position is funded by the Quality Improvement Program, California Department of Education (CDE), Child Development Division (CDD).

Standards *(continued from page 3)*

Some of our more fortunate child care programs enjoy the luxury of sharing a school nurse because of their location or sponsorship. When speaking to the school nurse, be sure to mention the national standards for child care programs. Maybe the nurse is unfamiliar with the standards your quality program is expected to meet. It's possible that conflicts and misunderstandings will disappear. In fact, it would be a good idea to share this article with your nurse right away.

For the programs not so fortunate, information and help using these standards are available at the National Resource Center for Health and Safety in Child Care Web site at http://nrc.uchsc.edu/. You may also contact the Healthline at (800) 333-3212. ❖

See the Resources section (back page) for information on ordering *Caring for Our Children*.

Inclusion *(continued from page 9)*

pound can overcome the medical risks, but are still at high risk for developmental delays or disabilities as they get older.

Those who work with children with developmental delays or high-risk conditions can profit from the research by linking families with early intervention services. Any family whose child, aged birth to 3 years, is at risk for poor developmental outcomes should be referred to the local Regional Center. Regional Centers are required to perform a multidisciplinary evaluation that includes vision, hearing and developmental assessments. Not every child is assessed, so parents or child care providers who continue to have concerns should persist in their efforts.

If you do not know how to reach the Regional Center in your area, call the Healthline at (800) 333-3212 or the California Department of Developmental Services at (800) 515-BABY.

It is critical to establish a diagnosis and, as early as possible, help families and child care providers access resources through disability-specific organizations, associations and parent-to-parent groups. These resources will enable caregivers to keep up with current research, learn day-to-day intervention strategies, and provide ongoing support for the family and child. ❖

Health and Safety Calendar

January

8-10: 3rd Annual Conference: Coming Together, Oakland. California Head Start Association. (916) 484-5750; online at www.ca-headstart.org.

16-22: Healthy Weight Week. Healthy Weight Network, 402 South 14th Street, Hettinger, ND 58639. (701) 567-2646. Materials available at www.healthyweightnetwork.com/hww.htm.

February

11-17: National Child Passenger Safety Awareness Week. In local communities across California, there will be National Child Passenger Safety Week activities. Go to www.nhtsa.dot.gov.

March

6-8: Eighth Annual Family Literacy Conference, Los Angeles. CA Dept. of Education, (916) 657-3832.

7-9: California Child Development Administrators Association Conference (CCDAA), San Francisco. (510) 744-9280, ext. 25.

15-17: CAEYC Annual Leadership Day, Conference and Exhibition, San Diego. California Association for the Education of Young Children, (916) 442-4703; www.caeyc.org/conferences.

Resources

Products, books, furniture and posters described in this section are brought to your attention so that you can see what is available. *Child Care Health Connections* does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

ERIC/EECE has three new, free digests: *Parent-Teacher Conferences: Suggestions for Parents* (also available in Spanish); *Selecting Culturally and Linguistically Appropriate Materials: Suggestions for Service Providers*; and *Adopted Children in the Early Childhood Education Classroom*. Write ERIC/EECE, Children's Research Center, University of Illinois at Champaign-Urbana, 51 Gerty Dr, Champaign, IL 61820; Call (800) 583-4135 or visit online at www.ericeece.org.

Improving Health Care Quality: Opportunities for Intervention by Consumer Groups is offering a free document that contains practical outreach and education strategies to help consumer groups effectively impact health care policies and practices. Call (213) 383-4519 or visit www.healthcarerights.org.

Ten Ways to Fight Hate is a free publication that includes ways communities can promote tolerance and includes a list of resources. Southern Poverty Law Center, 400 Washington Ave, Montgomery, AL 36104; online at www.splcenter.org.

Boost America will be distributing educational materials to all elementary schools and child care centers in the United States to teach children and parents about proper booster seat use (sponsored by the Ford Motor Company). www.boostamerica.org.

Online Resources

Child Safety Resources are available from SafeUSA to help children stay safe at home, at school and in their communities. www.cdc.gov/safeusa.

Immunization resources are available from the Centers for Disease Control: Visit online at www.cdc.gov or call the National Immunization Hotline at (800) 232-2522 (English) or (800) 232-0233 (Spanish).

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Graduate School of Public Health, San Diego State University

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CCHP welcomes new staff members

CCHP's remarkable growth over the past year is already translating into new programs and services for California's child care community, which means new staff members to support those programs. Meet our newest team members:

Judith Kunitz, MA (Human Development), started with CCHP in July 2000 as a Technical Assistant (TA) for the Child Care Health Linkages Project. She brings a wealth of expertise in child development and direct service, having spent 20 years as an early childhood educator in the Bay Area. For the past six years, Judith has owned and operated *Health and Safety First!*, a training agency supporting child care providers and others. Judith will also support Health Consultants throughout California.

Marie Nix, MS (Psychology), comes to CCHP's Map Project from an award-winning career as a university instructor, researcher, child development instructor and consultant at the University of Georgia. Her experience includes child development, child abuse prevention, and child advocacy. She also spent three years as a Project Manager at the Yemassee Primate Center in North Carolina

(continued on page 11)

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Hooray for health consultants and health coordinators!

by Lyn Dailey, PHN,
and Judith Kunitz, MA, Child Development Specialist

By the time you read this, the long-awaited Child Care Health Linkages Project will be alive, well and linking—perhaps in your own community. This California Children and Families (Prop. 10) Commission-funded effort has created a statewide system of child care health consultant services to ensure children enter school healthy and ready to learn.

We received 38 letters of intent to apply for the grants, and 32 counties in turn submitted full applications. At the time of this writing, applications are being read and scored by a dedicated task force. You may already know if your county was selected for funding and are celebrating this linkage of early childhood education and public health.

Part of the Child Care Health Linkages project involves training teachers to serve as Family Health Coordinators in their own programs. Family Health Coordinators will serve as the point person or onsite coordinator for health and safety issues. They can serve as the liaison between the staff and Health Consultant to identify and prioritize areas to be evaluated or where improvements need to occur. The Family Health Coordinator works with the Health Consultant to promote health and safety in the child care program on a daily

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Child Care Health Connections
March-April 2001
Volume 14, No. 2

***Child Care Health Connections** is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.*

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*Information provided in **Child Care Health Connections** is intended to supplement, not replace, medical advice.*

Visit us on the Web:
www.childcarehealth.org

Ask the nurse . . .

by Terry Holybee, RN

We have had three children with strep throat so far this winter. I don't think we'll ever get rid of it. What can I do to limit this disease in my family child care program?

Wintertime brings on many illnesses, and strep throat is one of the more common ones experienced by both children and adults. Considered to be a mild infection, strep throat is caused by the bacteria, Group A Streptococcus. The bacteria are often found in the throat and on the skin. They are responsible for causing impetigo (a contagious, acute skin infection), ear infections, scarlet fever and rheumatic fever. Some people carry the bacteria in their nose and throats without ever showing symptoms of illness, making it easy to spread from one person to another.

The streptococcus bacteria are spread through direct contact with mucous from the nose or throat (coughing and sneezing), or through contact with infected wounds. The symptoms for strep throat include a very red and painful throat accompanied by fever, tender or swollen glands, headache and stomach ache. Sometimes there is a cough or runny nose. Symptoms appear two to five days from the time of exposure. Strep throat is probably contagious before symptoms appear and continues to be contagious until treated with antibiotics.

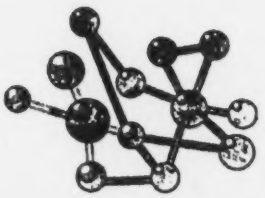
It is up to the child care provider whether or not a child with a sore throat is excluded or not.

It is up to the child care provider whether or not a child with a sore throat is excluded or not. If the child is not feeling well and is not able to participate in the daily activities, then the child should be excluded. If a medical diagnosis of strep is made, the child should stay home until he/she is well enough to participate in all activities. If antibiotics are prescribed, they should be completed as directed by the health care provider. *When antibiotics are stopped too soon, a stronger infection can return, delaying the child's return to health.* Only a medical professional can diagnose strep infection, so be sure to refer the child to prevent serious complications such as rheumatic fever.

To help limit the spread of illness, providers can follow these steps:

- Make sure all children and adults are performing careful handwashing.
- Teach children to cough and sneeze into their elbow, and wipe noses with clean tissues; throw the tissue into the wastebasket and then wash hands.
- Discourage sharing of food, drinking cups and eating utensils.
- Limit close contact such as kissing.
- Open windows and maximize outdoor play—fresh air helps. ❖

Infant/toddler care



From Neurons to Neighborhoods: The Science of Early Child Development

by Cheryl Oku, Infant/Toddler Specialist

Funded by the Quality Improvement Program, California Department of Education (CDE), Child Development Division (CDD)

The capacity to learn and absorb is simply astonishing in the first years of life. I've been fascinated and bewildered by the explosion of knowledge about brain development. All this new information has only raised more questions and complicated the challenges for infant/toddler caregivers. What influences early brain development? What is the impact of child care, family stress, early intervention?

These and other questions are asked and answered in *From Neurons to Neighborhoods*. Recently released by the National Academy of Sciences, it provides an excellent, highly readable overview of the most recent scientific knowledge about early childhood development. Its conclusions and recommendations are grouped in four themes:

1. All children are born wired for feelings and ready to learn.
2. Early environments matter and nurturing relationships are essential. Although society tends to focus on children's academic achievement, their social and emotional development is just as important. Research shows that early relationships are especially critical and that cultural values and practices are an important part of the bonds formed early in life.
3. Society is changing and the needs of young children often are not being addressed. Despite the economic upswing and higher levels of education, young children are more likely to be from poor families where parents work more hours. Record numbers of infants and toddlers are in child care.
4. Policy and practice are often based on little or no evidence that they promote children's well-being. The time has come for society to recognize the significance of those who care for children, and the importance of stability and quality in these relationships.

The report recommends ways to foster sustained relationships between young children and qualified caregivers, address the special needs of children with developmental disabilities or chronic health conditions, and ensure that all child care settings are safe, stimulating and responsive. It recommends major funding to support initiatives aimed at increasing the qualifications, pay and benefits of child care professionals, and to increase quality and decrease turnover. It issues challenges regarding the balance of work and family life, racial and ethnic diversity, integration of children's cognitive and emotional development, and more. ❖

From Neurons to Neighborhoods: The Science of Early Childhood Development, by Jack P. Shonkoff and Deborah A. Phillips, Eds. National Academy Press, Washington, D.C.; 2000. The book and executive summary can be read on the National Academy Press Web site www.nap.edu.; the full report can be obtained from the National Academy Press at (202) 334-3313 or (800) 624-6242.

***Editor's Note:** Betty Bassoff, DSW, Founder and Former Director of CCHP, and now a consultant to the Program, offers these additional insights on Cheryl Oku's report on the science of early child development.*

The myths about child development

by Betty Bassoff, DSW

The exciting research findings of the last several years regarding early brain development, while of great importance, have tended to distort the reality of child development in the public mind.

A recent report from the National Academies of Science (Oct. 3, 2000) debunked many popular myths about the early childhood period. For example, while considerable evidence exists regarding how early experiences influence brain development, the neurological window of opportunity does not slam shut at age 3 or 5. Brain development begins before birth, continues throughout life, and is influenced by both genetics and the surrounding environment (forget the old "nature/nurture" argument). The old saying, "He's just like his dad" is essentially untrue, as the combination of genes and environment can never be the same for both. He's really "just like himself."

Another myth that needs debunking is the belief that special programs are guaranteed to accelerate early learning: Little hard scientific data exists about how enrichment activities affect early brain development. The example given is the "Mozart Effect," which suggests that exposing children to classical music boosts their brain power, a theory never tested on young children. However, it is clear that well-designed intervention programs to help disadvantaged children can make a difference. More and better evaluation is needed to learn how this happens and what interventions are most effective.

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The right drug for the right bug

Overuse and misuse of antibiotics hinders its effectiveness

by Elissa K. Maas, MPH, Director of Community Health, California Medical Association Foundation

The Alliance Working for Antibiotic Resistance Education, AWARE, is a long-term project attempting to remedy the public's fixation on antibiotics as cure-all medicine. Antibiotics are powerful medicines designed to kill bacteria, but because of both overuse and misuse, we are experiencing a dramatic increase in the number of bacteria which have developed resistance to these drugs. The arsenal of antibiotics is losing its punch!

Led by the California Medical Association Foundation, AWARE is a partnership that includes physician organizations, health care providers, health systems, health plans, public health agencies, consumer groups and community based health organizations, federal, state and local government representatives and the pharmaceutical industry. Its goal—to reduce the inappropriate use of antibiotics in order to slow the spread of antibiotic resistance—is to be accomplished through education efforts geared to both health care providers and consumers.

AWARE focuses on both the relationship between physicians and their patients, and on patient responsibility to use antibiotics appropriately. Three overriding goals shape the project:

- Change physician and health provider behavior regarding the use of antibiotics to treat infectious disease;
- Change consumer awareness, understanding and behavior regarding the appropriate use of antibiotics; and
- Mobilize the community to reduce the inappropriate use of antibiotics.

A key component of the AWARE campaign is to work closely with child care providers in California. Children in child care settings are at greater risk for many childhood illnesses and the spread of infectious diseases is accelerated. Children in child care, as well as children in homes exposed to tobacco smoke, have the highest rate of infectious diseases in young children, including otitis media (ear infection), pharyngitis (throat infection), pneumonia, bronchitis and sinusitis. In addition, children in child care centers take up to three times more oral antibiotics per year than children who stay at home. As a result, children in child care centers have become "reservoirs" for drug-resistant bacteria.

Through the AWARE program, we will be developing materials in 2001 for those who provide education and training to child care providers as well as for child care staff and families on the importance of using antibiotics appropriately.

If you would like more information about AWARE or would like to be involved in this critical child health project, contact Elissa Maas, MPH, Director of Community Health, CMA Foundation at (916) 551-2555, email her at AWARE@calmed.org or visit our website at www.aware.md. ❖

CCHP is forming exciting new partnerships

by Marsha Sherman
Executive Director, CCHP

The California Child Care Health Program is growing by leaps and bounds. As we begin our work with counties to establish Child Care Linkages Projects, we are also forming new partnerships—links with health and safety organizations.

The health and safety communities recognize the importance of the child care community and the value of linking with them to assure the health of California's children. The California Medical Association Foundation (CMAF) and the American Academy of Pediatrics (AAP) are among that group.

Research within the health community has established that the overuse of antibiotics is a serious threat to children and adults. Child care providers often refer sick children for medical care, and have policies that will not allow children back to child care until the child is taking antibiotics. We will be working with the CMAF and AAP to inform the child care community on this issue and to establish healthy inclusion and exclusion policies for staff and children in child care programs.

This issue of *Child Care Health Connections* includes the first of many more articles from the CMAF on this and many other concerns. If you have any feedback or questions, please share them with us through our Healthline at (800) 333-3212.

We are looking forward to this new link and anticipate an increase in communication between the medical and child care fields. ❖

Preventing a national epidemic: childhood obesity

by Gail Gonzalez, RN

According to *Field Lessons*, a publication of the California Center for Health Improvement, and *Healthy Generations*, a publication of the Maternal and Child Health Division of Epidemiology at the University of Michigan, the incidence of obesity in our children has shown a dramatic increase. Four states had 14 percent of their children labeled as obese in 1991; by 1998, 47 states, including California, reported the same numbers.

We live in a society that fosters obesity in children who are genetically predisposed toward the condition. Children are eating more fats and sugars, eating fewer fruits and vegetables, and leading more inactive lives than ever before. The availability of fast food and snacks, and the number of hours spent with TVs and computers have a direct impact on a child's growth and development. Consider parents' beliefs about food, feeding and overall health. The sense that a fat baby is a healthy baby and the use of food for comfort, reward or bribery supports unhealthy food habits. Some of our very young children spend the majority of their day with a caregiver other than their parent, who also influences the child's environment and development.

Obesity is dangerous because it can set the stage for adult health problems such as high blood pressure, Type 2 diabetes, and high cholesterol. Caregivers need to be aware of and responsive to children's feeding cues (both hunger and satisfaction). While adults are responsible for what food choices are available and how food is presented, children are responsible for how much they eat.

The preschool years are important for learning movement and developing motor skills. Physical activity programs at the preschool age need to focus on teaching these skills. Active play can go a long way to preventing unhealthy weight gain, and should emphasize activities that can be learned, enjoyed and chosen for a lifetime, not ones that prepare children for competitive team sports.

We know that we have profound influence over children's development in the early years including the formation of eating habits and the enjoyment of physical activities. As parents, we owe it to our children to learn more about nutrition and health and model healthy behavior. When you choose child care, be sure that your healthy habits are modeled there as well. This is another opportunity for child care programs to partner with parents to improve the life of our children. Don't miss it. ❖

Preventing childhood obesity

Daily planned play with the children that requires being active indoors and outside, and involves adult family members, can help prevent obesity. Children need aerobic activity daily as well as free play. Try walking, running, marching, dancing, swimming, climbing or any other activity that makes you breathe harder and makes your heart beat faster. Have fun!

Some points to remember:

- ***Offer nutritious meals and snacks.***
- ***Encourage physical play.***
- ***Reduce or eliminate TV, videos and computer games.***
- ***Promote breastfeeding.***
- ***Encourage healthy eating habits and model healthy behaviors.***

Join the CCHP Advisory Committee

Help CCHP to help your community!

CCHP's Advisory Committee is growing in exciting, energizing ways! The committee is a culturally diverse, multidisciplinary group representing the child care and health communities from all corners of California. If you are interested in representing your discipline, exchanging information, developing new contacts, and guiding the growth of the California Childcare Health Program, please contact Thomas Brennan at 510/288-7908 or tbrennan@childcarehealth.org for more information.

Biting in the Child Care Setting

Biting causes more upset feelings than any other behavior in child care programs. Because it seems so primitive, we tend to react differently to biting than we do to hitting, grabbing or other aggressive acts. It is upsetting and potentially dangerous; it is important for caregivers and parents to address this behavior when it occurs. Though it is normal for infants and toddlers to mouth people and toys, and for many 2-year olds to try biting, most do not continue after the age of three.

Why do children bite and what can we do?

Children bite for many different reasons, and careful observation will guide your appropriate and effective intervention.

Taking the time to understand why this individual child bites is invaluable in changing the behavior while maintaining a positive caregiving relationship.

Watch to see when and where biting happens, who is involved, what the child experiences, what happens before and after.

Ask yourself why the child bites others. Is there a pattern to the situations, places, times or other children when biting occurs? What individual or temperamental needs might influence the child's behavior? Have there been changes in the child's health, family or home situation which might affect his/her behavior?

Adapt your environment, schedule or guidance methods to teach gentle and positive ways to handle the child's feelings and needs.

When a child bites another child:

Intervene immediately between the child who bit and the bitten child. Stay calm, don't overreact, yell or give a lengthy explanation.

When a child:	You can:
Experiments by biting	• Immediately say "no" in a firm voice. • Give him a variety of toys to touch, smell and taste and encourage sensory motor exploration.
Has teething discomfort	Provide cold teething toys or chewy foods such as frozen bagels, teething biscuits or bananas.
Is becoming independent	• Provide opportunities to make age-appropriate choices and have some control (The pretzel or the cracker? The yellow or the blue ball?) • Notice and give positive attention as new self-help skills and independence develop.
Is using muscles in new ways	Provide a variety of play materials (hard/soft, rough/smooth, heavy/light).
Is learning to play with other children	• Try to guide behavior if it seems rough. (Take the child's hand and say "Touch Jorge gently. He likes that.") • Prevent conflicts by offering more than one of any especially attractive toy and creating open play space. • Reinforce pro-social behavior (like taking turns with toys or patting a crying child).
Is frustrated in expressing his/her needs/wants	"Read" the child and say what he is trying to communicate. ("You feel mad when Ari takes your truck." "You want me to pay attention to you.")
Is threatened by new or changing situations such as a mother returning to work, a new baby, or parents separating	• Provide some special nurturing and be as warm and reassuring as possible, adding some stability and continuity to the child's life. • Help the child talk about feelings even when he or she says things like "I hate my new baby."

Talk briefly to the child who bit. Use your tone of voice and facial expression to show that biting is not acceptable. Look into the child's eyes and speak calmly but firmly. Say, "I do not like it when you bite people." For a child with more limited language, just say "No biting people." You can point out how the biter's behavior affected the other child. "You hurt him and he's crying."

Help the child who was bitten. Comfort the child and apply first aid. If the skin is broken, wash the wound with warm water and soap. Apply an ice pack or cool cloth to help prevent swelling. Tell the parents what happened, and recommend that they have the child seen by a physician if the skin is broken or there are any signs of infection (redness or swelling). Encourage the child who was bitten to tell the biter "You hurt me."

Encourage the child who bit to help the other child by getting the ice pack, etc.

Observe Universal Precautions if there is bleeding.

Alert the staff to the incident.

Notify the parents of all children who were involved. Let them know what happened but do not name or label the child who bit. Reassure them by telling how you handled the incident, and involve the parents in planning how to prevent and handle future biting.

When biting continues after several weeks:

Plan a more concentrated program of intervention:

Meet with the parents of the child who is biting to discuss possible reasons and plan together to change the biting behavior.

Assign a special person to stay with the child, to carry out the plan determined by the parents and staff with the aim of teaching and giving positive attention for acceptable social behavior.

When the child bites, use the techniques listed above and remove the child from the area where the biting took place. Tell the child he or she cannot play in the area where the biting took place for a while. (This is redirection, not a "time-out.")

If the child continues biting or does not seem to care about the consequences, seek professional help and/or explore the possibility that the child needs an environment with fewer children and more one-on-one adult attention.

Older preschoolers who continue to bite should be referred for more assessment and help.

What can programs do to handle biting?

Develop a policy for guidance and discipline which includes biting. Clearly state how you will handle biting occurrences for both the child who was bitten and the child who bites.

Communicate your policy with parents and staff before biting occurs. Reassure parents that this behavior is not uncommon and that you plan to work with the child in developing positive social skills.

Prevent biting by being alert to potential problem situations:

- Evaluate your program for stressors such as changes in providers or children, crowded play areas which make children wait for turns, schedules requiring children to make many transitions, tired children at the end of the day.
- When a child is starting in your program, ask the parents whether biting or other aggressive behavior has been an issue and how it has been handled in the past.
- Be alert for children who are likely to bite based on past history.
- Remember that biting tends to be more common during the late summer and early fall months (perhaps due to lighter clothing or changes in the grouping of children).

Reinforce desired behavior. Notice and acknowledge when you like what the child is doing. Provide positive guidance for showing empathy or social behavior, such as patting a crying child, offering to take turns with a toy or hugging gently.

Help the child make connections with others. Encourage special relationships with caregivers, talk about how others feel, express empathy for the feelings of other children.

Do not label, humiliate or isolate a child who bites another child.

By Cheryl Oku, Infant-Toddler Specialist
(Revised January 29, 2001)

References: *Guide to Social-Emotional Growth and Development*, The Program for Infant/Toddler Caregivers, Far West Laboratory and the Child Development Division of the California State Department of Education, 1991. *Biting, A Fact Sheet on Preschool Children's Behavior*, Seattle-King County Department of Public Health, Date March 19,1992. *Children Who Bite*, by Donna Witmer, Scholastic Pre-K Today, March 1998.

Policies for safe travel in child care

by Sara Woo, MPH, Project Coordinator, Safely on the Move

Spring and summer can offer fun and educational field trip opportunities for children as long as they are planned well. Be sure to review your field trip/transportation policies before traveling with children. Discuss the specific points with parents and staff before the field trip to ensure that everything is clear. Listed below are recommendations and practical ideas for safe travel.

Vehicle requirements (car, van, truck or bus)

- Meets state vehicle licensing laws.
- Heater and air conditioner work.
- Regular servicing and safety checks.
- Have a back-up vehicle available in case of an emergency or last minute changes.
- ***During trip:***
  - Keep in the vehicle:
    - Proof of vehicle insurance and registration
    - First aid kit
    - Binder or clip board with: safety checks, vehicle service records, emergency procedures, injury report forms (the same ones child care usually uses), and trip records (when, where and who traveled)
  - Keep vehicle doors locked and windows opened only slightly (if needed).
  - Remove or keep sharp or heavy objects in the trunk.

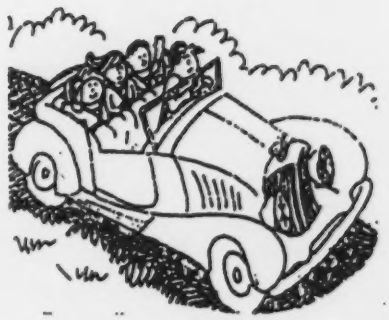
Driver requirements

- 18 years or older with current driver's license
- Select drivers based on experience, driving record and safe driving habits.
- ***During trip***: NO smoking, NO loud music or cell phone use while driving; NO drinking alcohol in the previous 12 hours before the trip; NO use of any drugs that cause drowsiness or impair judgment.

Planning ahead

Trip leader:

- Develops a checklist with vehicles/drivers and children assigned to each. Be sure there is adequate insurance coverage for the trip.
- Ensures that an adult with first aid and pediatric CPR training rides in each vehicle.
- Provides name tag including the name and phone of the child care program for each child (some programs provide each child with a brightly colored tee shirt containing the program name and phone).
- Ensures that staff/child ratios as mandated by child care licensing are maintained. More adults allow for smaller groups, easier supervision of children and more fun.
- Counts children before leaving, when arriving and periodically during the field trip to ensure that no child is left behind. Ensures that children are supervised at all times.
- Selects someone with child passenger safety training to check for proper child restraint use before leaving (call the Healthline at 800/333-3212 or 619/594-4373 for training information).



- Checks that all children under age 13 ride in the back seat in their own useable child passenger restraint. (For best protection, children under 40 lbs. ride in a safety seat with a harness; children over 40 lbs. ride in a booster seat until the vehicle seat and belts fit well.)
- ***Give each driver:***
  - A map with the field trip route, the closest hospital and the pick-up and drop-off points clearly marked (give to all parents, too).
  - A clipboard with the names and copies of the emergency cards of all children riding in the vehicle.
  - A cell phone (for emergency use).

For further information, contact the Healthline at (800) 333-3212 or (619) 594-4373. ❖

Sources:

Model Child Care Health Policies, American Academy of Pediatrics, 3rd Edition, June 1997.

National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs, Maternal and Child Health Bureau, 1992.

Should staff or volunteers drive on field trips?

Many child care programs may already have a policy specifying that only volunteers can drive on field trips. Some recently published information questions this practice due to liability issues.

Watch for more articles on this topic in future issues of *Child Care Health Connections*. Meanwhile, check with your automobile insurance and business insurance agents to find out what their position is on this issue. Follow their advice to make sure you are protected in the event of a crash.

BEST COPY AVAILABLE

Inclusion Insights

Get involved in moving toward inclusion

by Sandra Zehaye, M.A., Project Specialist

Halfway through the 20th century, more people began to acknowledge children, who until then had been "seen and not heard." If a child had a disability, he or she might have been tested, labeled and put into a special program, which may have been far away from home. Prior to this time, that same child might have been ignored, abandoned or sent to an institution forever.

In the late '70s and early '80s, specialists began to identify children with special needs early in their lives. As a parent, you were told that your child would receive part of his/her child care or education in a classroom with typically developing children. This was referred to as *mainstreaming*. Families were finally being given some choices, because a range of special services was now becoming available.

During the '90s, parents and advocates began to voice concerns about "equal and fair" in child care and education. These advocates worked at the national level to encourage the reauthorization of IDEA (Individuals with Disabilities Education Act) and the enactment of the ADA (Americans with Disabilities Act). Their goal: That children with disabilities and other special needs be included in appropriate environments alongside their typically developing peers and have special services provided within the classrooms. This approach is called *inclusion*.

Research has shown that the benefits gained from including children with disabilities and other special needs in group settings far exceed those gained from isolating children in specialized settings.

The goal, passion and intense desire to have children with special needs included in the same settings as their typically developing peers encouraged a shift in how programs were designed to serve families and children. This moved us to inclusion. Research has shown that the benefits gained from including children with disabilities and other special needs in group settings far exceed those gained from isolating children in specialized settings.

The Map to Inclusive Child Care Project, along with many other program leaders and advocates, supports the mission of expanding opportunities for children with disabilities and other special needs. Its goal is to continue to support the national and state agenda to eradicate barriers that exist to include children with disabilities and other special needs in child care. This agenda will require a number of steps to fully implement.

Would you like to help? One of Map's goals is to identify the many models of inclusive programs that exist across the state. You can get involved in moving toward inclusion by calling us at (510) 281-7937 to request your copy of the program profile. ❖

Diversity

Suggestions for developing positive cultural and racial attitudes in young children

- Initiate activities and discussions to build a positive racial/cultural identity.
- Initiate activities and discussions to develop positive attitudes toward racial/cultural groups different from the child's.
- Always answer a child's questions about race/culture when asked.
- Listen carefully to a child's questions and comments. Make sure you understand what the child means and what s/he wants to know.
- Pay attention to feelings. Find out what is involved in the questions or comments.
- Provide truthful explanations appropriate to the child's level of understanding.
- Help children explore their own ideas, giving them support for their efforts.
- Help children recognize stereotypes and prejudice.
- Encourage children to challenge racism by your own example and give them skills appropriate to their age.
- Cultivate the understanding that racism does not have to be a permanent condition; that people can work together to create change.

Adapted from "Serving Children from Biracial/Biethnic Families, a Supplementary Curriculum for the Training of Child Care Providers" published by the California Child Care Health Program. ❖

Health consultant's corner

What is the role of the child care health consultant?

by Judith Kunitz, MA, Child Development Specialist

A Child Care Health Consultant's basic role is to enhance the quality of child care programs by promoting optimal health and safety standards. The key word is *consultation*. As child care providers, we are not seeking experts who direct our work but rather a colleague whose expertise links with ours. In order to reach this goal, the Child Care Health Consultant should have a working knowledge of the culture and climate of early childhood education, and should seek to establish a respectful and responsive partnership with the child care providers in her community.

What aspects of child development and day-to-day child care experiences and practices should the Health Consultant be aware of? What can she/he offer children and families in child care? Certainly an awareness of early brain research and the ages and stages of child development is important. The consultant can then relate this growth to the developmental stages of potential common injuries and health issues, and work with the child care provider to prevent occurrences.

> ***As child care providers, we are not seeking experts who direct our work but rather a colleague whose expertise links with ours.***

The Health Consultant and the child care provider can work together to create quality child care. The ideal consultant should have a knowledge base of developmentally appropriate practices, accreditation, licensing regulations, appropriate child care facilities, materials and supplies, diversity issues and parent-teacher-child relationships. The Health Consultant should know about the different types of early childhood education (ECE) programs child care providers work in and the different types of ECE philosophies and curricula used (Montessori, Head Start, Reggio Emilia, etc.).

Child care providers need to help inform the Health Consultant on the day-to-day realities of our profession. Unfortunately, child care work is not highly valued in our society. Consequently, we are often overworked and underpaid, conditions which lead to high turnover rates. The challenge the Child Care Health Consultant faces is to respect individual differences and to draw on the rich experiences of child care providers while sharing expertise in the realm of the public health world. ❖

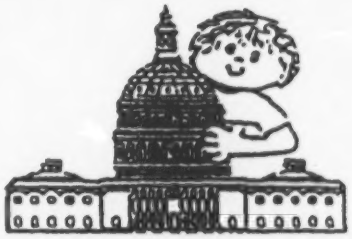
CHECK IT OUT!

www.childcarehealth.org

Our newly designed Web site not only has a new look, it is jam-packed with lots of new information for providers and parents. Take a look, and then please take a minute to tell us what you think. E-mail your comments to sevinger@childcarehealth.org.

Legislative update

by Marsha Sherman, Executive Director, CCHP



The current legislative year is just beginning, and all bills for the 2000-2001 legislative year will have been submitted by the end of January. We go to press on this newsletter issue before these bills have numbers, and we know there will be other bills which will impact the health and safety of children in child care.

CCHP has three priorities for this year:

- To extend the Child Care Health Linkages project to more counties — those not funded in this round of state Proposition 10 funding;
- To take action to establish viable support systems for child care providers in their struggle to meet the needs of more and more children with challenging behaviors; and
- To remove as many barriers as possible to child care for children with special health and developmental needs.

As always, your help and support are what make this effort a success. Stay tuned for the details and to learn what you can do to help us make these goals a reality. ❖

New CCHP staff *(continued from page 1)*

(yes, *primate*). She expects to receive her PhD in (human) Psychology soon.

As Coordinator of the Map Project, Marie will be involved in diverse activities surrounding inclusion, from program implementation to curriculum development.

Melissa Ryan, MSW, traded the large scale of the Regional Center of the East Bay where she was one of 100+ coordinators for the smaller scale of CCHP (her addition brings our staff to a record 21). She also traded Boston's snowplows for San Francisco's foghorns three years ago, and joined CCHP's Map Project in December 2000. In addition to running and knitting, Melissa enjoys reading literature and history—her undergraduate major.

We also say goodbye to ***Pamm Shaw***, who has moved on to CEITAN. She will continue to contribute to the Map project. ❖

Myths *(continued from page 3)*

Further, the prevalence of family problems in society such as substance abuse, depression, and family violence call for specialized expertise not typically available in traditional intervention programs. Research does confirm that early relationships are especially critical. Children who lack at least one loving and consistent caregiver such as a parent or a child care provider, may suffer from severe and long-lasting developmental problems.

The report ends with a number of important recommendations for changing national policy. Among these are: establishing a task force to review public investments in child care and early education; expanding coverage of the Family Medical Leave Act to all working parents (only 40 percent are covered now); exploring ways to support low income parents who take leave; and extending the "time-out" period for welfare families with infants. ❖

Linkages *(continued from page 1)*

basis, thereby maximizing the effective use of available resources. The Health Coordinator also works with children and families to ensure that they have access to affordable and appropriate medical, dental and mental health services.

Training for the Child Care Health Consultants and Family Health Coordinators will be provided by CCHP throughout the three years of the grant. Participants will learn the skills and become familiar with the resources necessary to develop the competencies required for their roles. Trainers will promote the National Health and Safety Performance Standards for Out-of-Home Child Care and will utilize a curriculum developed by our own Gail Gonzalez, R.N. (with help from multiple health, safety and child development specialists).

So what if you are in a county that wasn't chosen for funding under this grant? All materials developed by the project will be available online or for purchase. Health Consultant and Family Health Coordinator training may be available to other counties in the future. In addition, CCHP will be working to increase funding and thereby increase the number of counties funded. Watch the Health Consultant Corner column in this newsletter for project developments, or call Lyn (510/281-7907) or Judith (510/281-7929) for more information.

Congratulations to the lucky grantees! To those not funded, let's work together for future funding! ❖

Health and Safety Calendar

March

7-9: California Child Development Administrators Association Conference, San Francisco. CCDAA, (510) 744-9280, ext. 25.

15-17: California Association for the Education of Young Children Conference 200, San Diego. Contact CAEYC at (916) 442-4703; www.caeyc.org/conferences_tbl.htm.

April

National Child Abuse Prevention Month. For materials, contact the National Committee to Prevent Child Abuse, (800) 394-3366; www.parentsoup.com/library/organizations/bpd0325.html.

Governor's Office of Emergency Services' 18th Annual California Earthquake Preparedness Month. Visit www.oes.ca.gov/cepm2001.nsf, or call (510) 286-0895.

19-21: 19th Annual School-Age Care and Recreation Training Conference: Reach for the Stars to Create a Brighter Tomorrow, Sacramento. CA School-Age Consortium, (415) 957-9775; www.calsac.org.

22-28: National Infant Immunization Week. Contact the National Immunization Program at the Centers for Disease Control and Prevention, (800) 232-2522 (English); (800) 232-0233 (Spanish); or visit their Web site at www.cddc.gov/nip.

25: 24th Annual Public Policy Symposium, Sacramento Convention Center. Call CAEYC at (916) 442-4703, or visit their conference page at: www.caeyc.org/conferences_tbl.htm.

26-28: 10th Annual Conference/ Early Intervention: A Journey of Exploration and Discovery, Los Angeles. Infant Development Association of CA, (916) 453-8801.

Resources

Products, books, furniture and posters described in this Resources section are brought to your attention so that you can see what is available. Child Care Health Connections *does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.*

Documents and materials

Successful Strategies for Children's Health, Summaries of Fourteen Successful Children's Health Programs. Free from Action Alliance for Children, (510) 444-7138; email aac@4children.org.

School Readiness: Helping Communities Get Children Ready for School and Schools Ready for Children. Identifies key resources, programs and services that promote children's cognitive, emotional, social and language growth. Free from Child Trends, (202) 362-5580; online at www.childtrends.org/r_ed.cfm.

Online Resources

Blueprint on Optimal Breastfeeding Practices. From the Office of Women's Health, U.S. Department of Health and Human Services. Outlines action steps for education, training and support, and other resources. www.4woman.gov/breastfeeding/press.htm.

California Report Card 2000: How Young People Are Faring Today. From Children Now; the report contains data for children and youth on family economics, health, education and safety. www.childrennow.org.

Making an Impact on Out-of-School Time: A Guide. From the National Service Resource Center; includes tips for creating a quality program, program profile and resources. www.etr.org/nsrc/pdfs/niost/impact/impact.html.

Early Learning Through the Arts. From the Wolf Trap Foundation for the Performing Arts. Drama, music and movement activities for children ages 3 to 5. www.wolftrap.org/institute.

Child Care You Can Count On, from Annie E. Casey Foundation, has resources on child care affordability, school-age care, family child care, and professional development. www.aecf.org/publications/child/afford.htm.

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CALIFORNIA CHILDCARE HEALTH PROGRAM

Child Care Health Connections

A health and safety newsletter for California child care professionals
Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

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CCHP's new look

New projects, new services, new staff, new grants . . . about the only thing that isn't changing at CCHP is our commitment to enhancing the quality of health outcomes for children in child care. This issue of Child Care Health Connections launches our new look, created by graphic designers Eva Guralnick and Karen Soleau to reflect the breadth and depth of CCHP's endeavors.

In addition to the agency's new logo, each of CCHP's main areas of activity will have its own variation on that logo. This will help make it easier for our partners, colleagues and clients to recognize projects that are members of the CCHP family. Keep an eye out for the new logos—they're your assurance of multidisciplinary expertise and diverse experience united for California's children. ❖

Questions or comments on our new look? We'd like to here from you! Fax Sara at (510) 839-0339 or e-mail her at sevinger@childcarehealth.org

CCHP welcomes new staff

At CCHP, we continue to grow, bringing more services to more children, families, and health care and child care providers. Some of our new faces include members of *Safely on the Move*, CCHP's Child Passenger Safety Education Project.

Safely on the Move is a statewide project focusing on child passenger safety issues for children in child care settings. The project is headed up by Sara Woo, who has an MPH with a specialization in health promotion. Sara combines experience as a child care provider with a strong background in program development, training and technical assistance.

Working alongside Sara is Nini Chommanard, a San Diego State graduate student in Public Health. Nini took her BS in Health Science, with a concentration in community health education, and has experience as a child care provider and health educator. Together, Sara and Nini provide technical assistance through the toll-free Child Care Healthline, trainings, workshops, newsletter articles, and car seat checkups. In addition, *Safely on the Move* is collaborating with local child care resource and referral agencies to enhance their current child passenger safety resources and services.

Please join us in welcoming these new staff members—and take advantage of their expertise! ❖

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Child Care Health Connections

Child Care Health Connections© is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of Child Care Health Connections are published during the year in odd-numbered months at the subscription rate of $20 per year.

Newsletter articles may be reprinted without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit us on the Web:
www.childcarehealth.org

Ask the nurse . . .

by Terry Holybee, RN

Q *I have been very concerned lately about the threat of rolling blackouts. Can you give me some advice about what to do if our lights go out?*

A Everyone in California has had this concern over the past few months. In most cases, loss of power is not an emergency, but having a plan in case of a rolling blackout is well advised. When developing your plan, you should consider the two following issues: *Am I caring for medically fragile children who may be adversely affected by a loss of power? Am I able to provide an adequate environment for the children if the outside temperature is very cold or very hot?*

If you care for children who rely on electrically operated devices to provide breathing support, feeding or physical condition monitoring (such as apnea monitors, external heart monitors, breathing machines and ventilators or electrically operated feeding machines), you will want to make sure you have an adequate backup power supply for those devices, such as appropriate batteries or a generator. Verify how many hours of backup power supply are available for your use. Talk with parents about how you will manage the care of their child should a loss of power occur. Always give parents the option to come and pick up their child early.

If the weather outside is very warm or very cold, environmental comfort and safety are also important considerations when planning for blackouts. Licensing requirements state that room temperatures should range from 68°F to 85°F degrees. If loss of power affects your ability to maintain the home or center within that range, it may be necessary to send the children home for the day.

Listed below are other concerns that may affect you during a blackout:

- Cordless phones don't usually work when the power is off. Keep a cell phone or rotary dial phone handy in case you need to call parents or 9-1-1 for an emergency.
- Update your emergency packs and check your supply of batteries.
- Move your activities outside, if possible, if you have an absence of natural light in your home or center. Avoid the use of candles—use flash lights (and keep extra batteries handy).

Keep parents informed about your plan and the guidelines under which you developed it. If you have further questions, check with your licensing analyst, power company or the Healthline. ❖

References:

Special Licensing System Alert, Community Care Licensing Web site

National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs

Infant/toddler care

On crying: Going beyond "Hush little baby ..."

by Cheryl Oku, Infant/Toddler Specialist

Funded by the Quality Improvement Program, California Department of Education (CDE), Child Development Division (CDD)

When a baby cries, she is trying to tell you something. Usually it is easy to figure out what that is: "I'm hungry," "I'm wet" or "I'm frightened." But, sometimes, all your attempts to provide comfort don't work. It's frustrating to care for a baby who doesn't respond to you. And if the crying goes on for many days, you might begin to feel helpless and stressed. You just want to stop the crying and say, "Hush little baby..." What can a caregiver do?

Stay near and be as calm as possible

An inconsolable baby is often experiencing great sadness and confusion, and needs to express her sense of loss. Whether you are 2 years old or 42 years old, it's the same feeling of grief when you are not able to be with the person you most want to be with. She needs to experience the security of your presence. Stay with her and let her finish her crying, however long it takes. Reassure other children and parents that her needs are being met.

Try to understand and consider the causes

Physical pain or health condition: Is she eating, sleeping and developing well? Food allergies or a lack of sleep can cause unusual irritability.

Developmental Stage: When stranger and separation anxiety peak, babies are particularly sensitive to changes in care and may even have difficulty with established caregivers.

Individual differences: Children with "slow-to-warm" temperaments may take time to embrace a new caregiver or adjust to being in group care.

Ready to learn: Some children are ready to learn to take comfort in good-bye rituals, transitional objects, such as blankets or stuffed toys, or to learn other self-comforting skills.

Unmet emotional needs: Babies are sensitive to stress in the family, such as illness, changes in parents' work schedules or limited time and resources. This may lead to more sensitivity to fear and insecurity.

Do share your concerns with the parents and ask for their help. Together you can stay near to her and ..."she'll still be the sweetest little baby in town." ❖

WANTED: A nurturer, protector and guide for children

P. Marie Nix, Coordinator, Child Care Inclusion Services

As more children are receiving care outside of their homes, the role of child care providers in children's lives is increasingly important, especially for children who spend many hours daily in child care.

In support of Mental Health Awareness Month, this column is devoted to three basic components of healthy relationships on which child care providers can focus to support positive emotional development and well-being in all children.

> *Children develop best when provided a safe, stable and responsive environment.*

Children develop best when provided a safe, stable and responsive environment in which to explore their complicated worlds.

A safe environment is more than simply a danger-free environment. For all of us, and children especially, a safe environment is one in which the people in our lives provide us with unconditional love and acceptance that is not based on our accomplishments. Instead, individual differences are appreciated and celebrated as important elements of the emerging independent person each of us strives to become.

Stability in a child's life is central for learning to find our way predictably and successfully

(Continued on page 11)

Public Health

Healthy People 2010: A Health Odyssey

by Lyn Dailey, PHN

Just as it seemed we'd never reach the year 2001 in our lifetimes, it seems at times as if we may never reach our nation's public health goals. Every 10 years, a prevention agenda for the nation is developed. It is a statement of national health objectives to identify the most significant, preventable health threats and establish goals to reduce them.

The goals of Healthy People 2010 are: 1) to increase life expectancy and improve the quality of life, and 2) to eliminate health disparities. While life expectancy in the U.S. is increasing overall, there are still differences based on race, gender, income, disability, geographic location and sexual orientation. For example, infant death rates for African Americans are twice that of white infants, and men have a life expectancy six years less than women.

Healthy People 2010 objectives focus on efforts that promote healthy behaviors, create healthy environments, and increase access to quality health care. Progress is tracked by measuring certain "Health Indicators":

- physical activity
- overweight and obesity
- tobacco use
- responsible sexual behavior
- access to health care
- mental health
- injury and violence
- environmental quality
- immunization

As you can see, there is definitely a role for you to play in helping the nation reach the 2010 goals.

Think about the ways you can impact the health indicators listed, and seek out the resources to help you make progress:

- Help child care staff and parents stop smoking.
- Provide health insurance benefits for staff, and help staff and families apply for state health insurance plans.
- Serve meals and snacks low in processed foods and which contain lots of fruits and vegetables; encourage physical activity whenever possible.
- Assess immunization records for children and staff; make sure your facility is free of lead, pesticides and other toxins.
- Reduce injuries by completing a regular safety checklist, providing occupational health training for staff to reduce exposures to bloodborne diseases and prevent back injuries.

The list is endless, but so are the benefits. Get your children and families involved in making healthy lifestyle changes and celebrate successes. Check out the Healthy People 2010 Web site for more information at www.health.gov/healthypeople. ❖

Special Health Issue

Starting early: The rewards

by Betty Bassoff, DSW

The first national evaluation of the 635 Early Head Start programs serving 45,000 low-income children was reported in January of 2001 and received national praise for successes it demonstrated. The underlying question was: *Could early intervention with low-income families and their children 0 through 2 years of age produce improvements in the children's development on a number of cognitive (based on factual knowledge), language and social-emotional measures, skills critical to school success?* Additional questions concerned the families: *Do the services related to families affect parenting skills and behaviors, such as school and job-seeking?*

Following a year or more of the Early Head Start program, a sample of these 2-year-olds and their families was matched with a randomly assigned control group. The findings are of great importance to the quality child care campaign we are all waging. Compared to the control group, Early Head Start children at age 2:

- Scored higher on standardized assessments of infant cognitive development, had expanded vocabularies and used more grammatically correct sentences.
- Were less likely to score in the at-risk range of developmental functioning.
- Lived in home environments more likely to support and stimulate cognitive develop-

(Continued on page 11)

Parents can beat their fear of fevers by understanding them

by Rahman Zamani, Program Analyst

What is fever? Fever is a rise in body temperature above normal. Although the range of normal temperature varies depending on the method used, it is generally accepted that a temperature of more than 100ºF (38ºC) measured by any method is a fever.

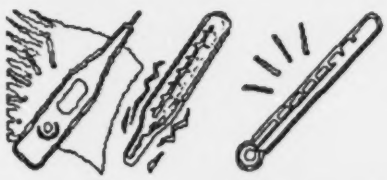
Fever is not an illness. In fact, a fever is one way the body fights infections caused by either virus or bacteria. It usually will not hurt your child.

How do you measure a fever? By feeling your child's forehead, face or chest you may know if he or she has a fever, but taking his temperature is the only way to know for sure. Although temperature measurement in children seems simple, the choice of method is complicated. It depends on your child's age, simplicity of use, cost, accuracy, choice of technology and the influence of advertising.

Ways to measure a fever:

- *By mouth* (oral method)—recommended for children older than 4 years
- *In the armpit* (axillary method)—recommended for infants and toddlers
- *Rectally* (rectal method)—not recommended for safety reasons
- *In the ear* (tympanic method)—requires special thermometers and training

When should you get medical help? Despite our concerns, fever is a common symptom for young children that is rarely harmful and usually does not require treatment. Mild or short-term higher temperature is common with minor infections and many other things including exercise, time of the day and environment (e.g., hot room or hot day). High fevers (temperatures of 103°F and up) or those rising rapidly, can signal a potentially dangerous infection.



In seeking medical help, the child's age and appearance are two major factors. While fever in newborns is rare and often indicates a serious problem, for older infants and children it depends on how the child looks and behaves.

Call the health care provider immediately if:

- The infant is 4 months of age or younger and has fever.
- The child between 4 months and one year of age has a fever lasting more than 24 hours.
- The child's fever is 104ºF and up.
- The child looks very sick, is not eating or playing, is unresponsive, or is having difficulty breathing unrelated to a stuffy nose.
- The child has other signs of illness such as stiff neck, rash, or a sore throat that has lasted for 2-3 days.
- The fever remains above 103ºF after an hour or two of home treatment.
- The fever lasts more than 2 days.

How do you manage a fever at home?

Without medicine: Fever doesn't always need to be treated. If active, playful and showing no other symptoms, the child may not need medication. Dress in light clothing to allow heat loss through skin, but use a light blanket if the child feels cold. Give extra fluids to prevent dehydration or extra loss of water.

With medicine: Medication is only needed to make a child more comfortable or when the child has seizures with fever. If you wish to treat a fever, acetaminophen (e.g., Tylenol) can be used to lower a fever. The child's health care provider can suggest the recommended pediatric dose. If the health care provider recommends Ibuprofen (Motrin/Advil), it can be used every 6-8 hours. *Always avoid aspirin because of its association with the sometimes deadly Reye's syndrome.*

Temperature tips

- Take young children's temperature in the armpit.
- Don't use temperature strips or pacifiers; they are not accurate.
- Do not use glass thermometers with mercury; they are dangerous.
- Wash the thermometer after use with warm (not hot) soapy water or swab with rubbing alcohol.

Health & Safety Notes
California Child Care Health Program

Latex Allergy and Sensitivity in the Child Care Setting

With more child care providers and health professionals following universal precautions to protect themselves from infections such as viral hepatitis and HIV, we are seeing an increase in latex allergies and sensitivities. Universal precautions require that child care providers wear protective gloves for any procedures that put them into contact with blood. The most effective, inexpensive and comfortable protective gloves are made from latex.

What is latex?

Latex is a milky liquid produced by rubber trees. It is used to make a wide variety of common household products such as protective gloves, balloons, disposable diapers, bandage tapes, pacifiers, rubber bands, bottle nipples, tires, toys and elastic in clothing, to name a few.

What is latex allergy?

Latex allergy or hypersensitivity is a reaction of the body's immune system to proteins found in natural rubber latex. Some people also react to chemicals in the gloves besides the latex itself. Sensitivity to latex can range from a mild skin irritation to a severe allergic reaction.

Reactions can occur from direct contact with products containing latex or from breathing latex particles in the air. Most latex gloves are treated with cornstarch powder to make them easier to put on and take off, and this powder binds with the latex proteins. When gloves are removed or snapped, they release the powder—along with the latex proteins—into the air.

What are the symptoms?

If someone becomes sensitive to latex, symptoms usually begin within minutes of exposure, but they can occur hours later and be quite varied.

- Mild reactions may cause skin redness, hives or itching.
- More severe reactions may cause respiratory symptoms such as itchy eyes, sneezing, coughing and asthma.
- Rarely, life-threatening shock may occur (but this seldom occurs as the first episode).

Who is at risk?

Anyone can develop a latex allergy, but the following groups of people are at increased risk:

- people who wear latex gloves regularly, such as child care providers and health care workers
- children with spina bifida (a birth defect involving the spinal cord or backbone)
- people with other allergies or asthma
- people who have had multiple surgical procedures
- people who have allergies to certain foods, especially avocado, potato, banana, tomato, chestnuts, kiwi and papaya.

Latex allergy should be suspected in anyone who develops symptoms after exposure, and he or she should be evaluated by a medical provider to determine if the reaction was caused by exposure to latex.

What should I do if I am allergic?

If diagnosed with a latex allergy by a medical provider, you should:

- Tell your employer, clients and all health care providers that you are allergic. Do not rely on doctors, nurses or dentists to know this from your chart.
- Wear a medical alert bracelet and carry non-latex gloves for convenience.
- Know which products might contain latex and avoid them.
- If you have staff or children in your program who are allergic, post a list of products containing latex and try to replace as many of them as possible with safer alternatives.

BEST COPY AVAILABLE

- Consult your child care health consultant or health provider regarding preparation for and responding to emergencies (e.g., having auto-injectable epinephrine such as EpiPen and EpiPen Jr.) ready and knowing how to use it.

How can you avoid latex allergy?

- Reduce your exposure to latex by only using latex gloves when you really need to. Protective gloves of any kind are only one part of universal precautions, and handwashing with soap is the most important infection control practice. Wear vinyl gloves instead of latex for routine diaper changes, food preparation and procedures that do not expose you to blood (such as applying cream to a rash or cleaning up vomit). Remember that vinyl gloves are a less effective barrier after about 15 minutes of wear. Medical-grade vinyl gloves are also available for procedures involving blood.
- Use latex gloves without powder. This will reduce the amount of airborne latex.
- Do not use oil-based hand lotions because they can break down and release the latex in gloves.
- Always wash your hands after removing gloves.
- When you use latex gloves, try a larger size than you would normally wear so that you perspire less and trap less moisture under the glove.

Choosing Gloves

There are several kinds of gloves for you to choose from, and each has advantages and disadvantages. You will need to choose the right glove for the right situation.

- **Latex gloves** provide the most protection at the lowest cost and are the most comfortable for the majority of people.
- **Single-use vinyl and polyvinyl chloride gloves** do not contain latex and are appropriate for use in the child care setting when blood is not involved.
- **Medical grade non-latex gloves** provide maximum protection but are are generally more expensive. Consider a bulk purchasing arrangement through your Family Child Care Association.

Any disposable glove is acceptable for food preparation or routine diapering as long as you practice effective handwashing.

The most important point to consider is that not all disposable gloves will protect you from viruses like hepatitis B or C, or HIV. Be sure you are using a medical exam glove that meets EPA guidelines. Talk to a medical supply store or your pharmacist if you're not sure.

If you are searching for non-latex gloves, keep in mind that the term "hypoallergenic" is not regulated, and does not mean latex-free—it usually means there are fewer chemicals used to make them. Read the label or ask your pharmacist.

Also remember that gloves deteriorate over time, so no matter what kind of gloves you purhase, be sure to check the expiration date on the box and store extra boxes in a cool, dry, dark place.

Additional Resources

American Academy of Allergy, Asthma & Immunology
800-222-2762 or www.aaaai.org.

American Latex Allergy Association
888-97-ALERT or www.latexallergyresource.org.

Latex Allergy Help
www.latexallergyhelp.com

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Latex Allergy: A Preventive Guide. DHHS (NIOSH) publication No. 98-113. (Feb. 1999)

Latex Sensitivity: A Compilation of Articles & Reference Material. Ammex Corp. Kent, WA. (Summer, 1997).

Guideline for Latex Glove Users. Occupational Health and Safety Branch, Ministry of Labour, Toronto, Canada. (September, 1994).

ALERT: Preventing Allergic Reactions to Natural Rubber Latex in the Workplace. DHHS (NIOSH) Publication No. 97-135 (July 1998)

By Rahman Zamani, MPH and Lyn Dailey, PHN (3/8/01)

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Red imported fire ants are infesting Southern California

Adapted from literature provided by the California Department of Food and Agriculture

Red alert! Red imported fire ants are infesting Southern California.

The red imported fire ant is a tiny but aggressive reddish-brown ant with a fierce sting that leaves victims with painful, itchy welts. The insects have been reported in eight California counties: Los Angeles, Orange, San Bernardino, Riverside, San Diego, and in the agricultural areas of Fresno, Madera, and Stanislaus.

Fire ants build nests anywhere they can find moisture: lawns, gardens, woodpiles, fields and parks, even in the walls of homes. When attacking, hundreds of fire ants swarm and inflict painful stings within a matter of seconds. Within a few hours, the affected area itches, burns and develops blister-like sores that could become infected if not treated carefully. The ants are especially dangerous to small children, the elderly, pets and wildlife.

If you think you've found a fire ant mound or nest, don't disturb it! Call the California Department of Food and Agriculture (CDFA) toll-free at 1-888-4FIREANT (888/434-7326). If red imported fire ants are present, the area will be treated free of charge. Be sure to tell them you are a child care provider and the concern is serious.

To avoid getting stung: Before you or the children you care for walk or dig in the yard, look for signs such as raised mounds near plants, shrubbery or sidewalks; or flat patches of soil on the grass. Wear, and ask parents to send children to you with closed-toe shoes with socks when walking in the grass. You and the children should wear gloves when gardening or anytime you may be digging in the dirt with your hands. Be sure to talk to parents of children with allergies, so you are prepared in case the child could also be allergic to red fire ants.

If someone gets stung: Wash the stings with soap and warm water to disinfect the area. Treat with ice to relieve pain and swelling. Be careful not to scratch the blister that forms within a day or so of the sting to avoid infection. Keep the area covered so the children don't scratch. If you or a child in your care experiences symptoms such as dizziness, nausea, sweating, swelling of the affected area, headache or shortness of breath, immediately call your doctor or seek medical attention. You may be having an allergic reaction to the fire ant venom.

For additional information, visit www.fireant.ca.gov. ❖

Diversity

Cultural knowledge develops early

by Veronica Keiffer, Diversity Educator

The behavior of young children is influenced by various factors, one being culture. Culture—one's language, customs and rules of behavior—helps children develop a sense of "self" and ethnic identity. This is also true for biracial/bi-ethnic children. However, dual-heritage children may draw conclusions about who they are and about events in their surroundings based upon more than one culture or racial group.

By the ages of 3 to 5 years, most biracial children have begun to develop a greater social awareness of racial and ethnic differences, also referred to as "cultural knowledge." Cultural knowledge may include information from the child's various cultural backgrounds. For example, a child who is Jewish and African American may celebrate Hanukkah and Kwanzaa, and feel comfortable behaving according to each culture's rules at such events.

In addition, cultural knowledge helps children evaluate their surroundings and assign an emotion or behavior to situations they encounter. For example, a biracial child of African American and Caucasian descent, perceived as being black, can sense a teacher's discomfort and peers' surprise upon seeing his white mother (Teaching Tolerance, 1997). An experience such as this can be painful and confusing for a young child. Being sensitive and aware of the unique needs of biracial/bi-ethnic children can help create a child care environment that supports the development of dual-heritage children.

For more information on how you can better serve children from biracial/bi-ethnic families, please contact the Child Care Health Program Diversity Project at (510) 281-7915. ❖

Inclusion Insights

Natural environments

by C. Melissa Ryan, MSW

INCLUSIVE CHILDCARE SERVICES PROJECTS

You may have heard the term "natural environments" before, especially if a child with developmental delays is in your child care. But exactly what does this term mean and what are the implications for you as a child care provider?

Part C of the Individuals with Disabilities Education Act (IDEA) of 1997 outlines the services that children (age 0-3) with developmental disabilities are entitled to under the law. The concept of natural environments has been included in the law since 1989, but the 1997 and 1999 revisions emphasize it more strongly. The law defines natural environments as "settings that are natural or normal for the child's age peers who have no disabilities...to the maximum extent appropriate to the needs of the child." Examples of natural environments include community settings such as a play group, the family home and child care.

For children with disabilities who attend child care, parents may want to collaborate with the provider and early interventionist to have the services a child needs delivered in the child care setting. This allows the child to receive needed services with as little disruption as possible to the family's regular schedule. A child who is eligible for California's Part C program called Early Start may qualify to receive services such as specialized instruction, speech and language services, and physical or occupational therapy, though this is not an exhaustive list of services.

Initially, the collaboration may feel challenging for early interventionists if they are not familiar with child care settings, and for providers who might not be accustomed to having specialists in their home/classroom. However, it is also a great opportunity to collaborate and provide services in a way that significantly benefits the child and the family. Together with the family and service coordinator, this team works as partners to identify the strengths and challenges for the child, address any obstacles, and establish effective practices to create a successful environment that benefits all children and families in the child care program. ❖

Sources

Early Intervention Program For Infants and Toddlers With Disabilities, 34 C.F.R. 303 (1999).

Natural Environments and Inclusion, Young Exceptional Children Monograph Series No. 2, Susan Sandall and Michaelene Ostrosky (Eds.) 2000. Division for Early Childhood of the Council for Exceptional Children: Denver.

Health consultant's corner

New Child Care Health Consultants on horizon

by Gail Gonzalez, RN

Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Care (1992) is a substantial and useful document developed by the American Academy of Pediatrics and the American Public Health Association. It examines the national guidelines, regulations and standards needed for quality child care.

Standard number 63 states, *"Each center or large family child care home and organized (small) family child care home shall use the services of a health consultant."* This standard makes good sense if we can assure that the health consultant understands how child care is delivered and the regulations governing services. Each of us working in child care has had the experience of asking a friend, neighbor, child's parent or our own physician to help out with health and safety concerns. It has been reported the help provided has often been disappointing. This is because health professionals are seldom trained in the unique issues relating to group care.

In California, Healthy Child Care California and the Child Care Health Linkages Project of the California Child Care Health Program are changing that picture. We are developing a specific curriculum to train interested

(Continued on page 10)

Legislative update

by Marsha Sherman
Executive Director, CCHP

Childcare Health Linkages, also known as Assembly Bill 383 (Chan), would establish and fund Child Care Health Consultants and Family Health Coordinators throughout California. These professionals would promote linkages among health and child care professionals and the children and families they serve. If that sounds familiar, it may be because you've also heard about CCHP's just-launched Child Care Health Linkages Project, funded by the California Children and Families (Prop. 10) Commission. AB383 would help transition Child Care Health Linkages from an exemplary project in select counties to a firmly established resource available to all California communities.

As this goes to press, AB383 is being reviewed by the Assembly's Health Committee. While Linkages may make perfect sense to us in the child care and health care communities, it isn't always obvious to lawmakers, including the governor. Non-profits have some restrictions regarding pressuring legislators and the governor to vote a particular way, but there are no restrictions on educating them to understand the impact of legislative issues on child care and health care providers.

Share your experiences and insights by writing, phoning, faxing or e-mailing your state assembly or senate representative. To find contact information, visit www.ca.gov, and navigate to the senate and assembly sites. You can also write to the bill's author: The Honorable Wilma Chan, State Capitol, Room 4098, Sacramento, CA 94249-0001. She'll make sure your letters get to the right committee at the right hearing.

How safe is your playground? Senate Bill 1703, authored by Senator Martha Escutia, was passed into law during the 1999-2000 session. It provides almost $16 million for repairs and improvements to playgrounds in centers and schools operated by the state or non-profit contractors. The California Department of Education is scheduled to issue applications for funding in mid-March 2001, so time may be short. For more information, visit www.cde.ca.gov. ❖

Product watch

The Consumer Product Safety Commission (CPSC) continues recalling several portable cribs/play yards that can collapse and entrap a child. CPSC is aware of 14 deaths to children when the top rails collapsed. A new standard requires that the top rails of play yards automatically lock into place when the unit is fully set up.

Baby Trend of Ontario, Calif. is the newest recall in this effort. Baby Trend is offering a free, new play yard to consumers who find and return *Home and Roam* and *Baby Express* portable cribs and play yards. Call Baby Trend at (800) 328-7363.

Other cribs and play yards previously recalled include those made by Evenflo, Century, Draco and Kolcraft. For more information, call CPSC at (800) 638-2772 or visit www.cpsc.gov. *Share this with your parents!* ❖

Consultants (Continued from page 9)

health professionals as Child Care Health Consultants. CCHP has listened to child care providers and used observations and feedback from others to assure that the curriculum is appropriate.

The Child Care Health Linkages Project is developing a specific curriculum to train health professionals as Child Care Health Consultants.

CCHP's goal is to train 50 health professionals by September 2001. The first step is to understand child care as a profession and a culture, and what makes a quality program. The importance of sensitivity to families of children with special health and developmental needs—and to a diverse population in care —will be stressed throughout the training.

CCHP's goal is to train 50 health professionals by September 2001.

The regulations and standards that affect child care will be part of the training as well as how to relate to the needs of the child care community. We will develop linkages to health-related services important to children and families. Each consultant will have the support and training to assure they are linked to those local health and social services important to children, families and the child care providers.

The goal is to tie it all together to provide the child care community with a service that is relevant and effective for them. You can learn more about this training and Child Care Health Consultation by calling the Healthline. ❖

WANTED: A nurturer ...
(Continued from page 3)

through life's many challenges. This is particularly important for learning how to understand our social world. Infants and young children have limited experience being effective interpreters of and respondents to their own and others' emotional experiences. Accordingly, they must rely on the adults in their lives for consistent guidance that helps them understand both what they are feeling and how to respond in a socially acceptable manner. Accurately understanding and managing our emotions is the foundation for solid mental health throughout our lives and is necessary to positive overall health.

A responsive environment that fosters exploration is a core building block for the development of confidence and positive self-esteem in children. Children look to adults for guidance; when intimate adults restrict safe exploration, children begin to feel and believe that they are unable to be good decision makers.

Child care providers are a vital resource of love, guidance and support for children in their care. You make a difference! ❖

CHILDCARE HEALTHLINE

Got questions? We've got answers! Call the Healthline at (800) 333-3212

Starting early
(Continued from page 4)

ment, language and literacy.

- Had mothers who were more supportive, sensitive, less detached and more likely to engage in play to stimulate cognitive and language development.
- Had parents who were more likely to attend school or job training.
- Were in families that experienced reductions in parenting stress and family conflict.

When center-based and home-based approaches were compared, the report notes that centers were more effective in producing improvements in children's cognitive development while home-based and mixed approaches produced greater impacts on parenting behaviors and language development.

Future reports will assess whether these effects are sustained over time; however, past reports from longitudinal Head Start studies have already confirmed this outcome. What does this mean for us? It is a further demonstration to the public and support for child care about the importance of early, quality care to give each child a head start, and for the need to offer families support and "linkage" to services for all low-income families, not just those who are enrolled in Head Start. To read more on this new report, log onto www.mathematica.org. ❖

Health & Safety Calendar

May

1-31: National Mental Health Month. Materials are available by calling (800) 969-6642 x7539, or visit www.nhma.org

1: Worthy Wage Day. Ensure quality child care for children with adequate wages for child care workers. For information, contact the Center for the Early Childhood Workforce, 800-UR-WORTHY (800-879-6784). http://www.ccw.org/worthy_wage/wwday.html

5-12: National SAFE KIDS Week. National SAFE KIDS Campaign, (202) 662-0600; www.safekids.org

22-29: Buckle Up America! Week. Resources and information are available at the National Highway Traffic Safety Web site, www.nhtsa.dot.gov, where you'll find a *Buckle Up America* icon. Or call them at (888) DASH-2-DOT (1-888-327-4236).

30-31: Creating Partnerships for a Healthy Tomorrow, San Francisco. Sponsored by the Maternal and Child Health Branch, Calif. Dept. of Health Services. Contact Conference and Training Services, (800) 858-7743; or check the Events Calendar at www.rce.csus.edu/pdfs/cts_mch.pdf.

June

1: Stand for Children Day. "Building Our Voice and Vision for All Children." Advocate on behalf of children and families through community action. Contact Stand for Children at (800) 663-4032; www.stand.org.

Resources

Products, books, furniture and posters described in this Resources section are brought to your attention so that you can see what is available. Child Care Health Connections *does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.*

Documents and materials

Child Abuse Prevention Handbook and Intervention Guide outlines current laws and procedures for child abuse prevention, reporting and treatment. Free. Crime and Violence Prevention Center, California Attorney General's Office, P.O. Box 944255, Sacramento, CA 94244; online at www.caag.state.ca.us/cvpc/CAPH.htm.

Migrant Children: Education, Health and Human Services Departments Need to Improve the Exchange of Participant Information argues for standards-based classrooms to ensure that a child's learning is not jeopardized by moving frequently. HEHS-00-4. Free. Government Affairs Office, PO Box 37050, Washington, DC 20013; (202) 512-6000; online at www.gao.gov/audit.htm.

Race, Class, Culture, and Language. A Deeper Context for Early Childhood Education provides a structure for reshaping early childhood education programs. Child Development Training Consortium, 1620 N Carpenter Rd, Ste C-16, Modesto; CA 95351; (209). 341-1602; www.childdevelopment.org.

Online resources

Culturally Competent Communications from the National Clearinghouse for Alcohol and Drug Information, has tips for developing culturally sensitive messages and materials. www.health.org/govpubs/MS494/index.htm.

Immigration and Refugee Services of America has resources for social workers, health professionals, and others working with immigrants and refugees. www.refugeesusa.org.

Promoting Better Health for Young People Through Physical Activity and Sports identifies ways families, schools and communities can improve opportunities for physical activity. www.cdc.gov/nccdphp/dash/presphysactrpt.

CALIFORNIA CCHP CHILDCARE HEALTH PROGRAM

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CALIFORNIA CHILDCARE HEALTH PROGRAM

Child Care Health Connections

A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

July-August 2001 • Volume 14 • Number 4

Child Care Healthline

The Child Care Heathline provides a statewide, toll-free number for use by child care providers: (800) 333-3212. Its purpose is to provide information that will promote the health and safety of children, families and caregivers in a variety of child care settings.

CHILDCARE HEALTHLINE

The Healthline has two nurses to answer questions with the most updated and thorough information on child care issues such as infectious disease, child abuse, nutrition and more. The Healthline Services Team also includes specialists in the fields of Child Health and Safety, Infant/Toddler Needs, Child Behavior and Mental Health, Children with Special Needs, Child Passenger Safety and Diversity.

The Healthline offers services and resources in Spanish and English. We are also working to provide other language assistance as we develop more resources. ◆

We value your comments and questions regarding the newsletter's look and contents. Please email Health Connections at sevinger@childcarehealth.org, or fax to (510) 839-0339.

Injuries in Child Care Centers: Gender-Environment Interactions

by Abbey Alkon, RN, PhD

Although child care quality is known to affect children's socio-emotional development, it has not been studied in relation to children's injuries. The Preschool Environment Project examined the child characteristics (age, gender) and child care environments (quality, physical safety) that together affect injuries for preschool-aged children attending full-day child care centers. This two-year research study (1990-1992) included four urban child care centers and 360 children, ages 2-6 years old.

Teachers completed injury forms for any child who met the study definition of an injury, "an event resulting in bodily harm, reflected by a physical mark or a sustained complaint more than five minutes in duration." Child care quality was assessed using Harms' Early Childhood Environment Rating Scale, annual staff stability, and full-time to part-time staff ratio.

The results showed that the most common injuries were minor, such as bumps and bruises. Most children had an average of six injuries a year, and only 1 percent of the injuries required medical attention. Children in low-quality centers had *higher* injury rates than children in higher quality centers. Girls had the lowest

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Child Care Health Connections©

Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

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Information provided in **Child Care Health Connections** is intended to supplement, not replace, medical advice.

Visit us on the Web:
www.childcarehealth.org

ASK THE NURSE...

Is Talcum Powder Safe? The Baby Powder Controversy

by Tram Trinh, RN, MS, Child Care Healthline Coordinator

Q: Is it safe to use talcum powder around infants and small children?

A: The use of talcum powder has been a very common practice among parents, although many have switched to alternative products for diaper rash. Parents have used talc because they felt it provides better absorption, and therefore can prevent diaper rash. However, the use of powders has been researched and proven potentially harmful for infants.

The tiny particles in talcum powder are carried in the air like dust and can be easily inhaled by the infant. If talc is inhaled in large amounts, it can dry the mucous membranes and affect the child's breathing. Some infants have also suffered from shortness of breath, wheezing and complete obstruction of the airways. In some cases, infants died due to respiratory failure from breathing of the powder, while others developed pneumonia. Using baby powder is also not advised around adults and children with asthma due to the powder's irritating effect when inhaled.

Recommendations regarding the use of talcum powder:

1. Do not use talcum powder or cornstarch, due to aspiration and irritation risks. (There is no clinical benefit to using talc.)
2. Try using an alternative cream-based product for diaper rashes, such as over-the-counter diaper creams or petroleum jelly. (Using creams and medicated powders requires parent permission as a medication.)

If you can't give up talcum powder, exercise these precautions:

1. Apply powder by shaking it on your hands as far away from the baby's head as possible. Don't sprinkle the powder directly onto the infant's body. This prevents the creation of the "cloud of smoke" which occurs when one shakes the powder directly from the container.
2. Keep talcum powder in child-proof containers. Toddlers and young children often want to help change an infant's diaper. They can grab open powder bottles overzealously and cause spillage, or accidentally smother the infant with powder.

Over all, talcum powder does pose a risk to infants and small children due to the irritating effects and possible inhalation. Providers should exercise caution and develop safe practices. ◆

References:

Hazards of Baby Powder (1984), T. J. Wagner, Pediatric Nursing, March-April; 1(4): pgs. 124-125

Aspiration of Baby Powder (1985), W. H. Cotton, P.J. Davidson, The New England Journal of Medicine, Dec 26; 313 (26): 1662

INFANT/TODDLER CARE

Breastfeeding

by Cheryl Oku, Infant/Toddler Specialist
Funded by Quality Improvement Funds, Child Development Division, California Department of Education

Breastfeeding provides the best nutrition for babies, reduces the risks of illness, asthma and allergies and strengthens the bond between mother and child. As child care providers, we can support breastfeeding and this special relationship in many ways:

- Discuss the baby's feeding plan and schedule: how often, for how long, where and in what position.
- Let the mother know you support and understand the challenge of breastfeeding while she is working or going to school.
- Provide a space where a mother can comfortably breastfeed during the day and a plan for her to do this whenever possible.
- Talk together about how you plan to store and handle breast milk safely. (Call the Healthline for guidelines.)
- Suggest local resources which can offer support.

Be prepared to handle and discuss these typical issues, and not to judge parents' opinions:

- A baby may express strong preferences for formula or breast milk, and protest at changes to his routine. Feeding patterns will change when the baby begins to eat solid foods or develops new skills.
- A breastfed baby typically has smaller, more frequent feedings so you may need to adjust your routines.
- Breastfed babies will have more frequent bowel movements with a different consistency than formula-fed babies.
- When a baby is used to being comforted by nursing, you will need to help her develop some other ways to be soothed, such as a special song or favorite object such as a blanket. Some babies will develop their own self-comforting skills, sucking on their own fingers or cuddling with you.
- When a baby is sick, or the mother is temporarily unable to breastfeed, the child may need extra comforting and attention.
- Talk together about when and how she plans to wean and how you might be able to help the child during the transition. Be prepared for changes—weaning is hard on the mother and the baby.
- When a mother chooses to continue nursing a toddler or preschooler, your continued support will still be needed and appreciated. ◆

Resources:
"Ask the Nurse" column on breastfeeding, Child Care Health Connections July-August 2000
The Child Care Food Program, (800) 952-5609, www.cde.ca.gov/nsd/ccfp
The Nursing Mothers Counsel, (650) 599-3669, www.nursingmothers.org

The following source was inadvertently omitted from the previous issue's article "On Crying." "When a Child Is Inconsolable: Staying Near," Lois Barclay Murphy, Zero to Three Bulletin, December, 1988.

Welcome New CCHP Staff Members

Four new professionals have joined CCHP's expanding staff in the past months: three Technical Assistants (TAs) with the Child Care Health Linkages Project and a Diversity Specialist.

The Linkages Project has four TAs who provide support and resources to the 21 counties funded to facilitate collaboration between the child and health care communities.

Robert Frank brings 15 years' experience directing Head Start programs in urban, suburban and rural communities. Robb has a BA in Social Work and an MS in Education from CSU Hayward. Originally from the Boston area, Robb is an amateur thespian and enjoys traveling.

Diana Harlick comes to CCHP from Sacramento, where she worked with The Salvation Army and California's Department of Education. Her areas of expertise include grant development, policy analysis and technical writing. Diana earned a double bachelor's degree from UC Davis in Sociology and French. Diana's passions include writing and running; she has been competing in long distance events for years.

The Diversity Research and Training Project promotes multicultural competence among child care providers, including sensitivity to culturally diverse health practices and serving biracial/bi-ethnic children and families.

Veronica Keiffer holds a BA in psychology and behavioral science from San Jose State University, and is comp.eting

—continued on page 10

PUBLIC HEALTH

What's up with T.B. Testing?

by Lyn Dailey, PHN

In 1998, child care licensing, following the recommendations of the American Academy of Pediatrics, changed the tuberculosis screening guidelines for children. Previously, a T.B. skin test was required for *all* children entering child care. The revised LIC 701 (medical exam form) instituted a requirement to test only those children who are at increased risk for tuberculosis. Many child care providers became concerned that this change would result in undiagnosed cases of infection in children. (*Remember that an infection with the tuberculosis bacteria without active disease does not place others at risk.*) A recent study conducted by Kaiser Permanente Northern California and published in *Pediatrics, April 2001* may now lessen these concerns.

Researchers administered a nine-question survey to parents of children due for a routine tuberculin skin test. The questions were very similar to those on the licensing form for child care exams. "Increased risk" included children (or household members) born outside the United States, foster and adopted children, household members who have spent time in jail, prison or homeless shelters, children living or spending significant time in households with a person who tested positive for T.B. (including child care providers), and household members who were HIV positive.

The results indicate that the screening questions were effective at identifying children at risk for tuberculosis infection. This is important because testing all children regardless of risk results in a higher rate of "false positive" tests—meaning that the skin test inaccurately identifies a child as infected. Positive skin tests frequently require a chest x-ray and it is not desirable to expose children to x-rays unnecessarily. The best way to reduce T.B. in a community is to identify active cases of the disease, which can then spread to others. A truly positive test in a young child means that the child has recently been in close contact with another person who has tuberculosis disease, and this person can then be identified and treated.

If a child in your care receives a skin test, the parent must bring you proof of the test results. Parents should take the child back to their medical provider to check the child's arm for a reaction to the test within 48-72 hours of receiving the test. There are places on the LIC 701 and the "Blue Card" for immunizations to record this information. If you have questions about T.B. testing, call the Communicable Disease unit in your local health department, or the Child Care Healthline at (800) 333-3212. (*Testing requirements have not changed for staff and volunteers in child care programs. Check with your health department for recommended testing intervals for your community.*) ◆

The California Childcare Health Program's Prevention of Infectious Disease Curriculum has been revised and was being printed as we went to press with this issue of Child Care Health Connections. This curriculum discusses health and safety issues in the child care setting, including detailed advice on the best practices to reduce spread of disease. To order, call (619) 594-3728 or visit our Web site at www.childcarehealth.org.

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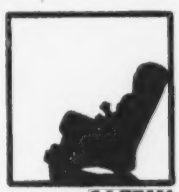
SAFELY ON THE MOVE

Transportation and Child Care

By Sara B. Woo, MPH,
Project Coordinator
Safely on the Move Project

Transporting children in child care can take many forms: safely driving children to and from child care, field trips, and transporting children in an emergency are all of concern to providers and parents. Sorting through all of the legal issues can also be overwhelming. Below are some guidelines to be aware of:

Child Care Licensing. California Community Care Licensing regulations for both family child care homes (Section 102417) and child care centers (101225) require that drivers be properly licensed; each child have their own seat; vehicles be maintained; each passenger be secured into an appropriate restraint system; and children not be left unattended in parked vehicles. Additionally, child care centers need to post a sign about the child restraint law at the facility entrance. Family child care regulations include an extra section on transporting infants.



Child Safety Seats. According to California state law (Vehicle Code 27360, effective January 2002), children need to ride properly restrained in a child safety seat or booster seat until they are at least 6 years old or weigh 60 pounds.

Safe Vehicles. The type of vehicle used to transport children should be considered carefully. Fifteen-passenger vans are three times more likely to roll over when carrying 10 or more passengers. Many children have been injured and killed when riding in them, and it is illegal for

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Facts about Meningitis

by Rahman Zamani, Program Specialist

What is meningitis? Meningitis is an infection of the membrane or thin lining that covers the brain and spinal cord, usually caused by a virus or bacterium.

Is it important to know the type of meningitis?
Knowing whether meningitis is caused by a virus or bacteria is important because the severity of illness, its treatment and the prevention of spread to other people are different.

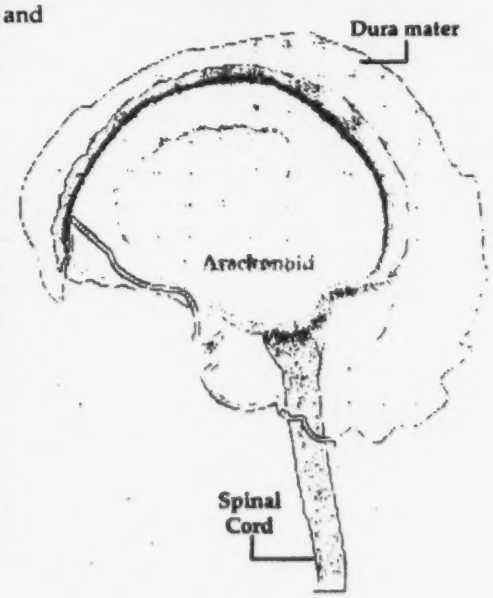
While viral meningitis is generally less serious and clears up within a week or two without specific treatment, bacterial meningitis can be quite severe and may results in complications such as brain damage, hearing loss, learning disabilities or death.

Who gets meningitis and how?
Although older children and adults can get bacterial meningitis, it is most common in infants and children under five years of age. Usually germs causing meningitis are carried in the upper back part of the throat. They are spread through coughing, kissing and sneezing.

Fortunately, none of the bacteria that cause meningitis are as contagious as the common cold or the flu. They cannot live outside the body for long, so they cannot be picked up by casual contact, water supplies, swimming pools, buildings or areas where a person with meningitis has been.

Sometimes, however, the bacteria have spread to people who have had close or prolonged contact with the patient. People in the same household or child care setting, or anyone with direct contact to the patient's oral secretions, would be considered at increased risk of getting the infection.

What are the signs and symptoms?
Young children with meningitis show symptoms of unusual irritability, loss of appetite, vomiting, fever and excessive, loud crying. Older children and adults may experience severe headache, fever, stiff neck and vomiting.



These symptoms may quickly progress to unconsciousness, convulsions and death. So, if any child displays symptoms of possible meningitis, he or she should receive immediate medical care.

Can bacterial meningitis be treated?
Bacterial meningitis can be treated with a number of effective antibiotics. However, it is important to start treatment early.

When should people with this illness return to child care?
People with meningitis generally feel too ill to attend child care. They can return when they feel better with no fever, or when the health care provider determines the disease is no longer contagious.

How can bacterial meningitis be prevented?
The best ways to prevent the spread of meningitis are to:

1. Always practice good handwashing and hygiene.
2. Make sure your children are appropriately immunized.
3. Immediately call your health care provider if you or your children come into close contact with infected people. You may be given antibiotics for protection against infection.
4. Do not share bottles, toys and other items placed in the mouth. ◆

Where can you get more information?

- *Child Care Healthline* at (800) 333-3212
- *Centers for Disease Control and Prevention (CDC)*—call (800) 232-2522 or (800) 232-0233 (Spanish) or visit www.cdc.gov/nip
- *Meningitis Foundation of America*—call (800) 668-1129 or visit www.musa.org

CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes
California Childcare Health Program

CHILDCARE HEALTHLINE

Excluding Children Due to Illness

Four steps to a healthier program

1. Start the day with a health check

Perform a brief and casual assessment of each child every day upon arrival and before the parent leaves. You are familiar with what is typical for each child and can identify "red flags."

- ***Listen*** to what the child and parent tell you about how the child is feeling. Is the child hoarse, having trouble breathing, or coughing? Did he or she eat breakfast?
- ***Look*** at children from their level. Observe for signs of crankiness, pain, discomfort or fatigue. Does the child look pale, have a rash, sores or runny nose or eyes?
- ***Feel*** the child's cheek and neck with the back of your hand for warmth, clamminess or bumps.
- ***Smell*** for unusual odors in their breath or diaper.

2. Distribute and explain your exclusion policies to parents and staff.

Have a clear, up-to-date exclusion policy for illness and provide parents with a copy. Ask your health consultant or a health professional to review it periodically. Writing a sound policy and enforcing it consistently will help reduce conflicts. Make sure all staff understand the policies and how to enforce them.

3. Understand the reasons for exclusion.

- The child doesn't feel well enough to participate comfortably in routine activities.
- The ill child requires more care than staff are able to provide without compromising the health and safety of the other children.
- The illness is any of the specific list of diagnosed symptoms or conditions for which exclusion is recommended.

4. Notify parents.

Inform parents of observed signs or symptoms, and promptly notify all families when a diagnosed communicable condition arises. Post a notice that includes the signs and symptoms to watch for, what to do, and when children with the condition can return.

Conditions for which exclusion is not recommended:

Certain conditions, by themselves, do not require exclusion unless recommended by the child's health care provider or the public health department. However, the reasons listed in step 3 still apply.

1. Fever in the absence of any other signs or symptoms of illness.
2. Presence of germs in urine or stool in the absence of symptoms of illness. Exceptions include potentially serious organisms such as E. coli 0157:H7, shigella or salmonella.
3. Nonpurulent conjunctivitis, defined as a pink eye with a clear, watery discharge and without fever, eye pain, or eyelid redness.
4. Rash without fever and without behavior changes.
5. Diagnosed CMV infection.
6. Carrier of hepatitis B virus, if they have no behavioral or medical risk factors such as unusually aggressive behavior (biting), oozing rashes or bleeding.
7. HIV infection, provided the child's health, immune status and behavior are appropriate as determined by that child's medical provider.

Symptoms or conditions for which exclusion *is* recommended:

For some conditions, exclusion can significantly reduce the spread of infection or allow children time to recover to the point where you can safely care for them:

1. **Fever along with behavior change or other signs of illness** such as sore throat, rash, vomiting, diarrhea, earache, etc. Fever is defined as having a temperature of 100° F or higher taken under the arm. Oral temperatures should not be taken on children younger than four years of age. Rectal temperatures are no longer recommended in the child care setting, and mercury-containing thermometers should be avoided. ***A temperature over 99° F (under the arm) in an infant under 4 months of age should be evaluated by a medical professional.***

2. **Symptoms and signs of possible severe illness** such as unusual tiredness, uncontrolled coughing or wheezing, continuous crying, or difficulty breathing.
3. **Diarrhea** - runny, watery or bloody stools.
4. **Vomiting** - more than once in a 24-hour period.
5. **Body rash with fever.**
6. **Sore throat with fever and swollen glands or mouth sores with drooling.**
7. **Eye discharge** - thick mucus or pus draining from the eye. (Viral conjunctivitis usually has a clear, watery discharge and may not require medication or exclusion.)
8. **Head lice or nits (eggs)**
9. **Severe coughing** - child gets red or blue in the face, or makes high-pitched whooping sound after coughing.
10. **Child is irritable, continuously crying,** or requires more attention and care than you can provide without compromising the health and safety of the other children in your care.

What to do when a child becomes ill in your program

- Attempt to keep the child from intimate contact with other children and staff. Remove and sanitize toys and other items they may have put into their mouth. WASH HANDS!
- Contact the parents to have the child picked up as soon as possible. Make the child as comfortable as possible. Do not isolate them in such a way that you cannot provide supervision at all times.
- Continue to observe the child for new or worsening symptoms.
- If the child does not respond to you, is having trouble breathing, or is having a seizure, call 9-1-1.
- Document your actions in the child's file with date, time, symptoms, actions taken, by whom, and be sure to add your signature.

When to get immediate help

Some conditions require immediate medical help. If the parent can be reached, tell them to come right away and to notify their medical provider. If the parent or the child's medical provider is not immediately available, call 9-1-1 (EMS) for immediate help.

Tell the parent to come right away, and get medical help immediately, when any of the following things happen:

- An infant under four months of age has an axillary ("armpit") temperature of 100° F or higher.
- A child over four months of age has an axillary temperature of 105° F or higher.
- An infant under four months of age has two or more forceful vomiting episodes (not the simple return of swallowed milk or spit-up) after eating.
- A child looks or acts very ill, or seems to be getting worse quickly.
- A child has neck pain when the head is moved or touched.
- A child has a stiff neck or severe headache.
- A child has a seizure for the first time.
- A child acts unusually confused.
- A child has uneven, different-sized pupils (black center spots of the eyes).
- A child has a blood-red or purple rash made up of pinhead-sized spots or bruises that are not associated with injury.
- A child has a rash of hives or welts that appears quickly.
- A child breathes so fast or hard that he or she cannot play, talk, cry or drink.
- A child has a severe stomach ache that causes the child to double up and scream.
- A child has a stomach ache without vomiting or diarrhea after a recent injury, blow to the abdomen or hard fall.
- A child has stools that are black or have blood mixed through them.
- A child has not urinated in more than eight hours, and the mouth and tongue look dry.
- A child has continuous, clear drainage from the nose after a hard blow to the head.

References

Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs. Washington, D.C.: American Public Health Association and American Academy of Pediatrics (1992).

Keeping Kids Healthy: Preventing and Managing Communicable Disease in Child Care. CA Department of Education (1994).

By Lyn Dailey, PHN Revised (May 2001)

California Childcare Health Program • 1322 Webster Street, Suite 402 • Oakland, CA 94612-3218
Telephone (510) 839-1195 • Fax (510) 839-0339 • Healthline 1-800-333-3212

Playground Safety

by Craig Hammer, MS, Certified Playground Safety Instructor and President, Serendipity Schools

California's new playground safety law has received a mixed reaction from child care center operators. All playgrounds except family child care homes must be inspected and brought into compliance with nationally recognized standards by January 2003. On balance, many child care providers agree that children have benefited and will continue to do so from the safety changes. Many have been surprised by how positive the upgrading experience has been. However, some of the new requirements—and some of the unintended consequences—offer serious challenges for programs that will not easily be overcome.

Inspection: While school districts and park operators have certified inspectors on staff, this has not been an option for most private programs. Their initial challenge has been just to find a certified inspector. In addition, inspectors are too often minimally trained, know little about early childhood education, are unqualified to discuss design factors other than safety, and are expensive. Conflict of interest concerns are a very serious problem when the inspector also sells equipment.

Use Zones: The areas around pieces of equipment ("use zones") may not overlap or have trees or shrubs growing in them, and must extend in all directions, requiring much more space than has been customary. Many programs will have to redesign their playgrounds, even removing otherwise fully-compliant equipment because of its closeness to a fence or a wall. Operators have two choices: have less stationary equipment, or install expensive composite structures that allow compact spacing of play activities.

Removing swings: Much more space is required of swings than before. This has too-frequently resulted in their removal. Equipment manufacturers may be encouraging this trend: they make very little profit on swings compared to virtually anything else they sell. Unfortunately, this very popular and developmentally significant piece of equipment will probably be part of fewer and fewer children's experiences.

The cost of implementation: Unfortunately, the cost of compliance is so high ($15,000 or more) many programs have decided to remove equipment altogether. To date, few grant or loan programs are accessible to for-profit programs.

PACE (the Professional Association for Childhood Education) is working to support the efforts of child care providers to make needed changes, and is interested in hearing from centers about their experiences. Send your story to cghammer@keyway.net. ◆

Census 2000: A Personal Response

by Veronica Keiffer, Diversity Educator

Being biracial is not something I think about day to day. However, come census time it is something I not only think about, but something that places my identity in the center of controversy. Being a person of African-American and European-American heritage comes with associated historical baggage as a result of our nation's history of slavery and racial classification. For example, society has imposed racial labels such as, "one drop of black blood makes you black." Although I am very proud to be a Black American, I am also proud of my mother and the European-American heritage she has passed on to me. The idea of having to choose means having to deny my mother, a part of myself. The recent debate about the option to fully identify all of your racial/ethnic and cultural background on the census has resulted in a successful advocacy movement. Now the census allows people of mixed race/ethnicity to fully identify themselves, a triumph for the multiracial community.

I feel it is important for mixed-race children to have the right to fully self-identify, particularly because identity is an emerging concept and an ongoing process which needs to be supported and embraced. Although race may indeed have been invented by society to maintain a particular status quo, it has very real social, political and economic ramifications. Thus, it is important that each of us as parents, child care providers, health care workers, teachers, etc., understand the significance of this issue and the right to self-identify. Census 2000 has meant that my voice is now heard, that society can no longer ignore my racial identity, and that there is a growing respect for the increasing numbers of those who identify with the mixed-race community. I am no longer an "other," someone without an identity or place in society. I am real and I am counted. ◆

Of the 285 million people counted by the Census 2000, almost 7 million checked more than one racial category. Of these, 93 percent checked two racial categories and 6 percent checked three racial categories.

Multiracial/multiethnic newborns now make up almost 15 percent of the births in California and account for 14 percent of births in other states. (Clegg, 2001; Hohman, 2001).

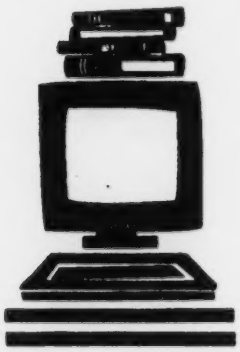
HEALTH CONSULTANT CORNER

Resources, Resources, Resources!

By Judith Kunitz, MA, Child Development Specialist

There are many online resources available to child care health consultants, family health coordinators and others interested in gaining more information about child care and public health topics and issues. This article will highlight just a few—check them out.

- **California Poison Control System:** A statewide network of trained experts who provide toll-free hotline information and advice about treating poisonings; www.calpoison.org.
- **Centers for Disease Control and Prevention:** The CDC is recognized as the lead federal agency for protecting the health and safety of people and providing credible information to enhance health decisions. This site also contains the ABCs of Safe and Healthy Child Care, an online handbook for child care providers; www.cdc.gov.
- **Center for the Childcare Workforce:** CCW is an agency that provides research, documentation, advocacy, training and organization around the issues of better compensation and working conditions in the field of early care and education; www.ccw.org.



- **Child Health Alert:** This organization is committed to the health and well-being of all children by helping parents, teachers and health professionals understand and make sense of health information which affects children; www.childhealthalert.com.
- **Healthy Child Care:** A bimonthly publication for child care programs devoted to health and safety issues; www.healthychild.net.
- **National Association for Family Child Care:** This agency provides technical assistance to family child care associations and others; www.nafcc.org.
- **National Association for the Education of Young Children:** NAEYC is the nation's largest organization of early childhood educators and others dedicated to improving the quality of programs for children from birth through third grade; www.naeyc.org.
- **What's Asthma All About?:** This site presents an interactive movie, favorite links and frequently asked questions about asthma; www.whatsasthma.org.
- **National Center for Health and Safety in Child Care:** Located at the University of Colorado, NRC's primary mission is to promote health and safety in out-of-home child care settings throughout the nation; http://nrc.uchsc.edu/. ◆

INCLUSION INSIGHTS

Child Care and Development

by C. Melissa Ryan, MSW

There has been much in the news lately regarding a 10-year study examining the relationship between child care and children's development, the "Study of Early Child Care" from The National Institute of Child Health and Human Development (NICHD). You have probably read the headlines and are aware of the controversy. There are serious questions about the conclusion that children who spend more hours in child care are more aggressive.

In 1989, NICHD set out to examine the relationship between the child care environment and children's development by following over 1,000 children from birth through age seven. The children were studied in a number of different child care settings across the country, including in-home care with the caregiver as someone other than the mother, center-based and family providers. The intent was to examine how certain aspects of child care, such as quality of care, affect a child's development.

INCLUSIVE CHILDCARE SERVICES PROJECTS

The research indicates that while family characteristics are the strongest predictors of a child's development, quality child care also contributes. For instance, high-quality care supports:

- better mother-child relationships
- fewer reports of children's problem behaviors
- higher cognitive performance of children in child care

—continued on page 11

—Welcome New Staff Members, continued from page 3

her doctorate at Mills College in Educational Leadership. Her job includes training trainers in the use of CCHP's Diversity Curriculum, developing the diversity collection in the library, and working to raise the consciousness of California's child care community regarding diversity and multiculturalism. In addition, Veronica administers the nonprofit she founded with her brother called The You in Me, which promotes diversity education through the arts. Born into a biracial/bi-ethnic family, Veronica and her brother watched their parents deal with a great deal of adversity while nurturing a passionate marriage and a thriving family. From this she learned that the most effective solutions are positive, creative ones. ◆

HEALTH AND SAFETY CALENDAR

September

5 – 7: Childhood Injury Control Conference, Sacramento. California Department of Health Services, Maternal and Child Health Branch, and CA Center for Childhood Injury Prevention. (619) 594-3691; www.cccip.org.

8 – 12: Sixth International Conference on Family Violence: Working Together to End Abuse, San Diego, CA. Family Violence and Sexual Assault Institute, (858) 623-2777; www.fvsai.org.

28 – 30: "One Voice for Children," Oakland. Professional Association for Childhood Education. For information call (800) 924-2460; http://www.pacenet.org conference.html.

PRODUCT WATCH

CPSC Consumer Alert: Hidden Hazard in Babies' Cribs

This May, the Consumer Product Safety Commission warned caregivers about the dangers of loose or oversized sheets in babies' cribs. CPSC has learned of the deaths of 17 babies since 1984, most under 12 months old, who suffocated or strangled when they became entangled in sheets in their cribs or beds. Two of these deaths were with fitted crib sheets. CPSC has worked to strengthen safety requirements for fitted crib sheets. An industry standard requires crib sheets to have a warning label that says "Prevent suffocation or entanglement. Never use a crib sheet unless it fits securely on crib mattress."

CPSC offers the following tips on ensuring a safer sleeping environment for babies:

- Make sure the crib sheet fits snugly on a crib mattress and overlaps the mattress so it cannot be dislodged by pulling on the corner of the sheet.
- Never use an adult sheet on a crib mattress; it can come loose and babies can become tangled up in it.
- Place a baby on his/her back on a firm, tight-fitting mattress in a crib meeting current safety standards.
- Remove pillows, quilts, comforters and sheepskins from the crib.

To get a free copy of the crib sheet safety alert, write to CPSC, Washington, D.C. 20207, email CPSC at publications@cpsc.gov, or visit the Web site at www.cpsc.gov.

Product Recalls

Feb 2001: Simmons Juvenile Products of Wisconsin is voluntarily recalling more than 68,600 cribs for repair. Bracket hooks that are used to position the height of the mattress can break, causing the mattress to collapse. Babies can become trapped and suffocate. Consumers should stop using these recalled cribs immediately and contact Simmons to receive free replacement brackets by overnight mail. Contact Simmons any time at (800) 421-2951 or at www.simmonsjp.com/recall.cfm.

May 2001: In cooperation with the U.S. Consumer Product Safety Commission and the National Highway Traffic Safety Administration, Evenflo Co. Inc. is recalling about 3.4 million Joyride® infant car seats/carriers. When the seat is used as an infant carrier, the handle can unexpectedly release, causing the seat to flip forward. To receive a free repair kit, call Evenflo toll-free at (800) 557-3178 anytime, or visit the Web site at http://www.joyridecarseat.com. (Consumers should have the car seat in front of them when they call or access the Web site.)

May 2001: Child Craft Industries, of Salem, Indiana, is voluntarily recalling about 4,300 changing tables. Some changing table joints were not properly glued and can separate, presenting a fall hazard to babies. Parents and providers should stop using the recalled changing tables immediately and call Child Craft at (866) 423-3114 between 8:30 a.m. and 5:30 p.m. ET Monday through Friday, or the firm's Web site at www.childcraftind.com. ◆

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LEGISLATIVE UPDATE

Legislation for Quality Child Care

by Marsha Sherman, Director and
Thomas Brennan, Executive Assistant

AB 383 (Chan), the Child Care Health Linkages Bill, is currently with the Assembly Appropriations Committee. CCHP consulted with Assemblywoman Chan's office in developing this bill, which would fund Child Care Health Consultants and Family Health Coordinators to enhance collaboration between child care and health professionals in communities throughout the state. The bill's supporters are working to keep it moving despite the energy crisis, which is diverting funds from programs.

SB 993 (Figueroa) is now called the Early Care Education Act (previously known as the Early Education and Wage Equity Act). The name change emphasizes the fact that SB 993 would help raise the quality of child care, not just the salaries of child care providers. Recruiting and retaining top-notch child care professionals are essential to ensuring high-quality care. SB 993 would also help keep currently operating centers open and establish age-appropriate educational curricula. This bill is important to assuring quality care.

CalWORKs: In May the governor traditionally revises the state budget, and Governor Davis' revisions this year included full funding for Stages One and Two of CalWORKs, to help people as they transition from welfare to work. However, the revisions left Stage Three, the critical stage that provides support (like child care) for parents who are now working, unfunded. The Senate and Assembly have found funding for Stage Three until July 2002. This buys a little time to negotiate a more permanent solution.

The California legislature now has a very powerful Women's Legislative Caucus. The efforts of this impressive group of 34 legislators have made, and continue to make, a difference in the quality and capacity to serve children. Be sure to ask your local legislator to join with this caucus to support child care.

Continue to write letters, send emails and make phone calls to elected officials; most officials calculate that one letter reflects the opinion of 300 constituents. To contact your representatives, visit www.state.ca.us and navigate to the senate, assembly, or Governor's pages. ◆

—Injuries in Child Care Centers, continued from page 1

injury rates in high-quality centers, but the highest injury rates in low-quality centers.

These findings show that the overall quality of a child care center may affect the health of children by providing environments that engage children in socially appropriate activities and reduce their risk of unintended injuries. In addition, girls were more vulnerable and sensitive than boys to their child care environments, since girls had the highest injury rates in the lower-quality centers. Although young children are expected to sustain some minor injuries, injury prevention efforts should focus on aspects of the child care environment that can reduce the number of injuries, such as staff stability, staffing patterns, and overall child care quality. ◆

Reference: Injuries in child care centers: Gender-environment interactions. (2000). A. Alkon, D.R. Ragland, M.J. Tschann, J.L. Genevro, P. Kaiser, W.T. Boyce. Injury Prevention, 6:214-218.

—Transportation and Child Care, continued from page 4

dealerships to sell these vehicles for official transportation of children to and from school or school-related events.

Vehicle Insurance. Sufficient auto insurance coverage for a child care program can be very costly. Some companies offer optional, non-owned auto coverage that covers a vehicle not owned by the program. As a result, it is common for volunteers to drive and use their own cars on field trips. Risks with volunteer drivers include difficulty getting an accurate picture of their driving record, their driving habits and their vehicle's safety-related maintenance problems.

See *Policies for Safe Travel in Child Care* published in the March/April 2001 *California Child Care Health Connections* newsletter for additional information on this issue, or contact the Safely on the Move Project at (800) 333-3212 or (619) 594-4373. ◆

Source:
Rules of the Road for Transporting Children. Bruce Hooker and Kentin Gearhart, Child Care Information Exchange, 9/99: p. 14-17.

—Child Care and Development, continued from page 9

- higher children's language ability
- higher level of school readiness

Despite what you may have heard on the news, this study tells us that high-quality child care does positively impact children's development. You, as child care providers who strive to give the best quality of care possible, make a difference in the lives of children! ◆

Source:

The NICHD Early Child Care Study (1998). Robin-Pierce, Public Information and Communications Branch, NICHD. (Web site: http://www.nichd.nih.gov/)

Resources

Products, books, furniture and posters described in this Resources section are brought to your attention so that you can see what is available. ***Child Care Health Connections*** does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and Materials

Bright Futures Family Pocket Guides: Raising Healthy Infants, Children and Adolescents has information for parents about health visits and child development. Single copy free. Federation for Children with Special Needs, 1135 Tremont St, 4th Fl, Boston, MA 02120; (617) 236-7210.

Making a Difference for San Francisco's Children is an analysis of the first nine years of the Children's Amendment in San Francisco. Free. Coleman Advocates, 459 Vienna St, San Francisco, CA 94112; (415) 239-0161; www.colemanadvocates.org.

Successful Strategies for Children's Health. Summaries of 14 successful children's health programs. Free from Action Alliance for Children (510) 444-7136; www.4children.org

Online Resources

America's Children and the Environment: A First View of Available Measures from the Environmental Protection Agency, assesses children's exposure to lead, pesticides and air pollution, and reports on increasing rates of childhood asthma and cancer; www.epa.gov/children/indicators.

Kids Oral Health Watch teaches adults the importance of children's oral health and how to advocate for improved oral health services; www.kidsoralhealthwatch.org.

Ideas for Funding Children's Programs, from Connect for Kids, is a tool kit on funding for children's programs and lists potential donors for child care, children's health and more; http://www.connectforkids.org/content1549/content_show.htm?attrib_id=299&doc_id=45947.

4 Kids. The Consumer Product Safety Commission Web site for children has information and activities on scooters, bicycles, helmets and other safety issues; http://www.cpsc.gov/kids/kidsafety/index.html. For more tips on bicycle safety and information on recalls involving bicycles and bike helmets, call CPSC's Hotline at (800) 638- 2772, or go to their Web site at www.cpsc.gov.

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CALIFORNIA CHILDCARE HEALTH PROGRAM

Child Care Health Connections

A health and safety newsletter for California child care professionals

Published by the California Childcare Health Program
Graduate School of Public Health, San Diego State University

September-October 2001 • Volume 14 • Number 5

New Chickenpox/ Varicella Requirement

As of July 1, 2001, all children enrolled or enrolling in child care will need to provide:

1. A record showing day/month/year of varicella (chickenpox) immunization on or after the first birthday, or
2. A health care provider's written indication that the child has a history of chickenpox disease (this may show up on the yellow shot record as a checked box for "had disease" under varicella). ◆

We value your comments and questions regarding the newsletter's look and contents. Please email Health Connections at sevinger@childcarehealth.org, or fax to (510) 839-0339.

Talking with Parents about Better Compensation for Child Care Staff

by Sara Evinger

"Parents Can't Afford to Pay; Teachers and Providers Can't Afford to Stay; There's Got to Be a Better Way!" The Worthy Wage Campaign slogan reflects the challenge of talking with parents about the need for better child care staff compensation. Policymakers, funders and employers will need to get involved to solve the urgent problem of high staff turnover and high costs to parents.

The first step to enlisting parents in efforts to improve compensation—whether writing letters to elected officials or spearheading a fundraiser—is to educate them about the effect of low wages on the quality of child care. For most parents working outside the home, child care is the fourth largest expense in the family budget, after food, housing and taxes. Yet it is expensive because young children need close attention if they are to thrive and grow in child care, and close attention means a low adult/child ratio and well-trained providers.

Many teachers are not earning a self-sufficiency wage. A family child care provider often works 10 to 12 or more hours each day. In 1999, the average salary of California child care workers was $16,140, and preschool teachers earned an average of $20,090. Entry-level public school teachers in California averaged $23,835.

—continued on page 3

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Child Care Health Connections©

Child Care Health Connections is a bimonthly newsletter published by the California Childcare Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

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Newsletter articles may be reprinted without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Childcare Health Program at the San Diego address below.

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Information provided in **Child Care Health Connections** is intended to supplement, not replace, medical advice.

Visit us on the Web:
www.childcarehealth.org

ASK THE NURSE...

New Licensing Checklist

by Tram Trinh, RN, MSN, Child Care Healthline Coordinator

Q: I am a provider at a child care center. What steps do we need to take to provide a secure environment for the children?

A: The key to security is preparedness. Does your center already have a plan in place? Do you comply with existing licensing regulations?

Licensing regulation references to assist in making your child care facility safer, and help you meet the minimum standards:

1. Criminal Record Clearances and Child Abuse Index Check (Section 101170)
2. Disaster and Mass Casualty Plan (Section 101174)
3. Fire Clearance (Section 101171)
4. Sign In and Sign Out (Section 101229.1)
5. Teacher-Child Ratio (Section 101216.3)
6. Telephones (Section 101224)
7. Responsibility for Providing Care and Supervision (Section 101229)

Licensing regulations are available online at www.dss/cahwnet.gov/getinfo/cacoderegs.html. (See Title XXII, Division 12, Chapters 1 and 3.)

Always begin with an assessment of safety and security measures already in place at your facility:

1. Review your facility to be sure it is secure, and that both children and staff feel safe from unwanted intrusion.
2. Contact your local law enforcement agency and request a safety inspection of your facility.
3. Develop a system of code words/phrases to use among staff in announcing an emergency.
4. Develop arrangements for mutual aid with other child care centers and schools in your area.
5. Develop two relocation sites to be used in case of emergency, and be sure parents know where they are and how to reach you there.
6. Develop a "phone tree" calling system among parents to be used in emergencies, and keep an up-to-date list of out-of-state contacts in case of a major disaster.

Other actions:

1. Install buzzers/signals on doors and outside gates to alert staff when someone enters or leaves the center, and security doors with coded buttons allowing only authorized entrance into the center.
2. Install mirrors on the corners of the building to offer better visibility.
3. Have a cellular phone available for emergencies. Know the cell phone company's correct emergency number—some do not accept 9-1-1 calls. Keep coins handy and know where the nearest pay phone is located.

You want to maintain a reassuring and comfortable environment for the children and parents. And when parents are asked what they want most in a child care program, the majority say it's a healthy and safe place. Involving parents in the early planning stages can be reassuring. ◆

Reference: Community Care Licensing: How to Make Your Child Care Center a Safer Place for Children (Child Care Facility Self-Assessment Guide), available online at http://ccld.ca.gov/docs/childcare/sags/SecurityIssuesInChildCare.pdf.

Beyond Handwashing: Healthy, Safe Routines

by Cheryl Oku, Infant/Toddler Specialist
Funded by Quality Improvement Funds,
Child Development Division, California Department of Education

Caring for infants and toddlers means spending lots of time together in feeding, diapering and other daily routines. Studies show that up to 80 percent of an infant's day involves caregiving activities which have a profound impact on a young child's health and development. Here are a few tips for making routines healthy and safe.

Greetings and departures

- Perform daily health checks for changes in health and signs of illness.
- Communicate important information about a child's health and well being to parents during these ideal times.

Feeding

- Sitting down to eat together helps prevent choking and baby bottle tooth decay. Eating together encourages good nutritional and social habits.
- Allergies to foods such as dairy products or peanuts are fairly common. Be sure everyone is aware of a child's allergies. Post in several places, such as the sign-in sheet, the refrigerator, the child's cubby or written on his placemat. Ask the parent for a written plan in case of a severe allergic reaction, and instruction in the use of medication (such as an Epi-Pen, Jr.) if needed.

Meals, playing, diapering and toileting

- Wash hands **before and after** eating, drinking, handling food, feeding a child, or giving medication; and **after** diapering and toileting, handling bodily fluids, cleaning up, playing outdoors, touching sick children or removing gloves. Singing a handwashing song will remind you and the children to wash thoroughly.
- Clean the diapering surface with soap and water. Dry with a paper towel, then disinfect with bleach solution and air dry to give the chemicals time to work.

Napping

- Check cribs regularly for hazards such as loose sheets, mattresses or hardware. Portable cribs should not be substituted for full-size cribs. Mesh-side cribs and playpens are particularly hazardous.
- Check the infant sleep setting for hazards such as overheating, loose or fluffy blankets, pillows, soft toys, crib bumpers or secondhand smoke. Always place infants to sleep on their back.

Caregiving routines are wonderful opportunities for babies and toddlers to have your undivided attention and care for a few minutes, to converse with you, to be a partner in care. Slow down and enjoy these special moments together. ◆

Resource:
It's Not Just Routine, 2nd edition by WestEd Module II: Group Care publications (video).

Funding for the Infant/Toddler Project comes from Quality Improvement Program, Child Development Division, California Department of Education.

—Talking with Parents about Better Compensation for Child Care Staff, continued from page 1

Low wages lead to high staff turnover. Roughly one-third of teachers will leave their jobs this year, most often to earn a better living elsewhere.

Last year Governor Davis signed AB 212, the Compensation and Retention Encourage Stability (CARES) bill, which will provide stipends for (state-funded) child care workers who take more professional courses. The California Children and Families (Prop. 10) Commission has set aside funds ($20.5 million in 2001-2002) to match local monies for child care compensation and retention. "Eventually, "says Rory Darrah with CARES in Alameda County, "child care workers should be paid as much as public school teachers."◆

Adapted from: Talking with Parents about Better Compensation for Child Care Staff (Center for the Child Care Workforce, Worthy Wage Action Guide, 1998) and Boosting Child Care Pay (Eve Pearlman in the Children's Advocate, March-April 2001).

Resource:
Creating Better School-Age Care Jobs: Model Work Standards (2001) defines good child care jobs and provides tools for assessing and improving the adult work environments. Cost: $10. Center for the Child Care Workforce: (202) 773-7700, email: ccw@ccw.org or visit their Web site at www.ccw.org.

"The quality of life in California 20 or 30 years from now will have a lot to do with the quality of child care today. The babies now in child care are going to be our workforce, our neighbors, our teachers, our doctors, and our future. If they start out life without the attention and stimulation they deserve, where will they be? And where will we be?"

—California Resource and Referral Network

PUBLIC HEALTH

Is Your Child's School Toxic?

by Lyn Dailey, PHN

Parents and caregivers are encouraged to take many steps to send their children off to school safely: health check-ups, immunizations, appropriate back packs, bike helmets, car seats and seat belts. But do you know if your child's school is free from pesticides and other toxic chemicals? There are steps you can take and resources you can obtain to help answer this question.

Indoor Air Quality

According to the Environmental Working Group (EWG), over two million California children attend school (and child care) in portable classrooms. Portables contain particle board, plywood, fiberglass, carpets, glues and other materials that release gases called volatile organic compounds (VOCs), some of which are linked with health and developmental concerns. VOCs include formaldehyde, benzene and toluene. Portables are often prone to leaks and can grow toxic molds. Class size reduction has increased the use of portables, particularly for child care and teen parent programs. For the report *Reading, Writing and Risk—Air Pollution Inside California's Portable Classrooms* visit www.ewg.org/pub/home/Reports/ReadingWritingRisk/pressrelease.html.

Pesticides

Pesticides and herbicides are widely used in schools to combat cockroaches, termites, ants, rodents and weeds. Many have been linked to short and long-term health impacts. The Healthy Schools Act of 2000 (AB 2260-Shelley) contains provisions to protect children in schools (and public child care programs in schools) from the hazards of pesticides. Under this law, schools must notify parents, teachers and children of most pesticide applications and adopt Integrated Pest Management (IPM) policies. For reports and more information on pesticide use in your school district, visit Pesticide Watch at www.pesticidewatch.org/Html/Schools/Schools.htm, and the California Department of Pesticide Regulation at www.cdpr.ca.gov.

Arsenic in Playgrounds

EWG has examined the use of arsenic-treated wood for playground structures, picnic tables and decking. Arsenic is injected as a preservative and pesticide into most wood used outdoors. It has been banned for pesticide use, but wood treatment is exempt from existing laws. Exposure to arsenic increases a child's lifetime risk of cancer. To read the report *Poisoned Playgrounds* visit www.ewg.org/pub/home/Reports/poisonedplaygrounds/capr.html.

Call your superintendent of schools or PTA for more information about your school district and specific schools. As more research into the effects of toxic chemicals on children becomes available, it is important to know when and where our children are exposed so that we can take steps to minimize the exposures. Our youngest children are frequently most at risk. Make Back-to-School a healthy move and check this out. ◆

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SPECIAL HEALTH ISSUE

Communicable Illnesses and Child Care

by Rahman Zamani,
Program Specialist

Every child gets infections whether in child care or not. However, children in child care are likely to experience more infections, especially in their first two years. This was backed up once again by a recent study published in the April 2001 issue of the *Archives of Pediatrics and Adolescent Medicine.*

The Early Child Care Study from the National Institute of Child Health and Human Development analyzed the health, child care, family and child development data of more than 1,200 participants. Its objective was to examine the relationship between experiences in child care and communicable illnesses throughout the first three years of life, and to investigate whether an increase in frequency of illnesses is related to language development, school readiness or behavior problems.

Results of the study showed that rates of illness were related to the number of hours spent in child care per week during the first year, and the number of other children in the child care setting. There was no evidence that increased rates of illness have a negative effect on other aspects of children's development, except perhaps a small increase in behavior problems.

Children in child care get sick two to three times more often with illnesses such as diarrhea, respiratory diseases and ear infections. In a group setting they come in close contact with other children, touch each other during play, share toys, put their fingers, toys and

—continued on page 11

Nutrition in Children Six Years and Older

by Susan Jensen RN, MSN, PNP
Child Care Healthline

Why is nutrition so important in children six and older?

There is a natural increase in appetite and activity level during these years. Good nutrition is necessary for normal growth of the body and brain and to maintain a healthy immune system. And it's never too early to learn good eating habits. A balanced diet can help prevent weak bones, heart disease, diabetes and obesity, now and in the future.

What if a child doesn't eat?

Few children eat as much food as a parent would like them to, but it's what they eat that's important, not necessarily how much. A healthy child will not starve. Many children like frequent, small meals or snacks throughout the day rather than several regular, big meals at traditional times. Even if the child doesn't want to eat, encourage him to sit with the family at mealtime and share the events of the day. Rules such as "you eat when we eat or not at all" create problems for children whose appetite is different from the family pattern. Working with your child's needs is not "giving in" or "spoiling."

What factors can affect appetite?

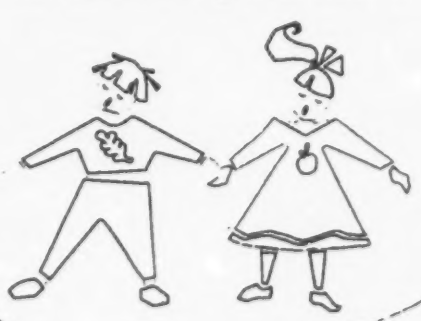
Inactivity. There is an alarming increase in the incidence of obesity, dental cavities, iron deficiency anemia and cardiovascular disease in children. It's up to parents to set the limits (less than two hours a day) on TV, computer and videogame use, and encourage outdoor play. It helps if these things are not located in the child's room.

Soda, milk and juice are filling and can curb appetite. Serve low-fat or non-fat milk, and 100 percent fruit juice, well diluted with water. Juice has a lot of sugar in it. A parent has little control over what foods the older child is getting outside the home, but you can control what you keep in the house. If the candy, soda, etc. are not there, neither is the temptation. **Diet soda and regular soda** have additives which are not good for growing children. Regular soda has so much sugar and additives that it would be "healthier" to give your child a bowl of sugar and water to eat.

What about picky eaters?

Don't make a big deal out of it. There are worse things than eating peanut butter and banana sandwiches every day for weeks on end. Let children help shop, cook and pack their own lunches. A child is more likely to eat (or at least try) something if she's helped plan and prepare it.

Few children eat as much food as a parent would like them to, but it's what they eat that's important, not necessarily how much.



How will I know if my child is getting enough of the proper vitamins and minerals?

Children do not need a vitamin supplement if they are eating a variety of grains, fruits and vegetables most days. Dairy products, beans, tofu, eggs, meat in small amounts, and dark green leafy vegetables supply protein, iron and calcium which support the growth needs of children. The vitamins and minerals from fresh foods are much better than supplements.

When should I worry?

Almost never, unless a child is ill, obese, losing weight, or eating only junk food. Take your child to see the pediatrician or nurse practitioner for regular check-ups, and get their recommendations regarding your individual child's growth pattern and nutritional needs.

Remember, children strive to be like their parents, so model good habits and eat healthy. ◇

References

Making Food Healthy and Safe for Children: Guidelines for Out-of-Home Child Care Programs. National Center for Education in Maternal and Child Health, Arlington, VA (1997).

Meals without Squeals: Child Care Feeding Guide and Cookbook, by Christine Berman, M.P.H., R.D. Bull Publishing Co., Palo Alto, CA (1997).

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CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes
California Childcare Health Program

CHILDCARE HEALTHLINE

How to Get a Child Tested: Guidelines for Special Education Assessment

Children with disabilities and other special needs may be eligible for special education and related services. If parents have concerns about their child's development, they should contact their local school district. The following guidelines can help you understand the assessment process.

Children ages 0 – 3

For children birth to three, the school districts provide special education services to children who are blind, deaf, deaf-blind, or have a severe orthopedic disability. Some school districts also provide services to infants/toddlers. The parents or legal guardian should contact their local regional center for assistance or call 800-515-BABY (800-515-2229) for local resources.

Early intervention services delivered within the context of the family can:

- Improve both developmental and educational gains
- Reduce the future costs of special education, rehabilitation and health care needs
- Reduce feelings of isolation, stress and frustration that families may experience
- Help children with disabilities grow up to become productive, independent individuals

Children ages 3 – 21

In order to determine whether a child 3 to 21 years old qualifies for special education services, s/he must be tested by the school district. Child care providers concerned about how a child moves, thinks, communicates, hears or sees should talk to the parent. The parent then contacts the school district, as well as their health care provider if appropriate, since the parent or legal guardian may make the initial referral and must sign the forms.

1. To initiate the process the parent or legal guardian should contact the local school district, ideally in writing. If writing a letter, it should state specific concerns and if possible, include observations made by the child care provider. The parents should date the letter and make a copy for their records. The parent may also want to provide a copy of the letter to the child care provider.

2. The school district must contact the parent within fifteen calendar days to sign an assessment plan and any releases of information to talk to other professionals involved with the child. The parent may also want to sign a release of information between the schools and the child care program to enable open communication and input.

3. The assessment plan is the written permission to allow the child to be tested. It should indicate which areas of development will be tested and the types of tests that will be used. Once the assessment plan is signed, a legal timeline begins for the school district to test the child.

4. Testing can take several hours, and young children may need to be assessed in phases, over a period of days or weeks. Parents can encourage the school district staff to observe the child in all settings, including the child care and the home. Testing should be done in the primary language of the family and is at not cost to the family.

5. If the child qualifies for special education, the school district has 50 calendar days to develop an Individualized Education Plan. Generally, a preschooler must have a significant delay in one developmental area or a moderate delay in two areas compared to their chronological age, or have a disabling condition or established medical disability.

   Assessment includes the following developmental areas and should identify strengths and abilities as well as delays:

   Adaptive: how children take care of themselves, including toileting, feeding, and dressing.

   Communication: how children understand, speak and use language.

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Cognitive: how children think and solve problems.

Fine and gross motor: how children use their muscles, eye-hand coordination, and other large and small motor tasks, including walking, running, jumping, and writing.

Social-emotional: how children interact with adults and peers, how they feel about themselves, how they make their needs known.

The child's health history is also taken into account and vision and hearing screenings may be recommended depending on the child's needs.

6. The IEP team determines the most appropriate services to meet the child's needs. The parents can invite anyone to attend the IEP with them, including the child care provider. Participating in these meetings may help child care providers coordinate services for the child and better understand the child's strengths and needs.

7. Special education services can be provided in a variety of settings, including a child care center, family child care home or in the child's home. The IEP team determines the type and quantity of services.

8. Once the parents sign the IEP, services can begin.

9. Even if the child does not qualify for special education services, the parents can ask the school district to make recommendations as to how the parent and child care provider can help improve the child's skills—suggested programs, activities, etc. The child's health insurance or another agency may cover services that could help, such as occupational therapy or counseling.

10. Parents should always request and keep copies of all reports, test results, and any other completed forms. With permission from the parents, child care providers may also want to keep copies of these forms on record.

The assessment process itself may help answer questions about the child's development and how to work with him. Assessment should be an ongoing collaborative effort between professionals and parents to understand warning signs.

Resources

Handbook on Developing Individualized Family Service Plans and Individualized Education Programs in Early Childhood Special Education Programs, and ***Handbook on Developing and Implementing Early Childhood Special Education Programs and Services,*** California Department of Education, Sacramento (2001). These handbooks may be ordered at (800) 995-4099 or www.cde.ca.gov/cdepress.

Early Warning Signs, California Department of Education, in collaboration with the California Childcare Health Program. Free pamphlet describing indicators which suggest that a child may need help.

Special Education Resources on the Internet at www.hood.edu/seri/serihome.htm. This site offers a collection of Internet accessible information for those involved in fields related to special education.

The National Information Center for Children and Youth with Disabilities at www.nichcy.org. NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families, educators and other professionals.

Idea Practices at www.ideapractices.org. This Web site has technical information about the federal law that guides special education, including the process of assessment, IEPs, and services.

The Healthline at (800) 333-3212 is a toll-free number available to the child care community for consultation on a number of different health and safety issues, including children with disabilities and other special needs.

Early Start for Infants and Toddlers with Disabilities and their Families at (800) 515-BABY.

Special Education Division, California Dept of Education at (916) 445-4613.

References

Handbook on Developing Individualized Family Service Plans and Individualized Education Programs in Early Childhood Special Education, California Department of Education, Sacramento, 2001.

Early Warning Signs, California Department of Education in Collaboration with the California Childcare Health Program, Sacramento 1999.

By Pamm Shaw, MS, Disabilities Specialist (June 15, 1999) Revised by C. Melissa Ryan, MSW (July 2001)

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Safely Back to School

By Sara B. Woo, MPH, Project Coordinator, Safely on the Move

Two special events in October offer actions you can take to help assure children are safer going to and from school or child care and home. International Walk to School Day on October 2, 2001 gives children in the U.S. a chance to be a part of a global event: last year over two million walkers took part in the effort to decrease the number of cars on the road, especially at school drop-off and pick-up times. National School Bus Safety Week, from October 21 to 27, is an annual, coordinated event to promote school bus safety.

Young children do not always understand the dangers of traffic and thus are at more risk for injury. In fact, not until they're at least 10 to 11 years old do children have all the skills they need to safely navigate traffic alone. Adult supervision and role modeling appropriate traffic safety rules, such as how to cross the street, are crucial in ensuring children are safe in traffic.

During the 1997-1998 school year, 125 pedestrians ages 5 to 18 years were killed during school transportation hours throughout the United States. Most injuries in school bus-related crashes occur inside the bus, while the majority of deaths involve children who are getting on or off the bus. From 1988-1998, an average of 31 passengers were killed each year in school bus fatalities while loading or unloading, and another 10 were killed in school bus crashes.

Preschool children are safest in the school bus when in child passenger restraints. Small school buses (under 10,000 pounds) must have lap belts in all seating positions. According to a new law (SB 568), "all school buses manufactured on or after January 1, 2002, and purchased or leased for use in California are required to be equipped at all designated seating positions with a combination pelvic and upper torso passenger restraint system." ◇

Important safety tips and information about getting involved with Walk to School Day or School Bus Safety Week activities can be found on the following Web sites:

Walk to School Day:
www.dhs.ca.gov/routes2school/
www.walktoschool-usa.org
www.iwalktoschool.org/

The Walking Bus
http://bigfoot.hsrc.unc.edu/wocs/usa_walk /logon/aussie.htm#bus

National School Bus Safety Week and bus safety resources
www. schooltrans. com/safeweek.htm
www.nhtsa.dot.gov/people/injury/buses/

Coping with Bullying

By Veronica Keiffer, Diversity Educator

As the children we care for prepare to return to school or enter new child care settings, so do the bullies who may be harassing them or their friends. Bullying has been defined as "intentional, unprovoked abuse of power by one or more children to inflict pain or cause distress to another child on repeated occasions (Child Alert, 1999)." The most common type of bullying is teasing or name calling, often around differences such as race, ethnicity, ability, religion or size. The child who is different from others can often become the target of a child who needs to show his strength by bullying or teasing.

As child and health care providers, we are concerned with how bullying affects the children in our care. A report entitled "Bullying and Psychological Health in Children" presented in the *British Medical Journal*, contends that a child who begins showing psychological, psychosomatic or behavioral problems may be dealing with a bully in her home, school or day care environment (R. Forero et al., 1999). Some common signs include bedwetting, sadness, low self-esteem, insecurity, anxiety, stomach aches and trouble sleeping.

Louise Derman-Sparks has some useful strategies for dealing with children's prejudice and discriminatory behavior:

1. Set limits. Make it a firm rule that a person's identity is not an acceptable reason for teasing or rejecting them.
2. Intervene immediately. Don't ignore or excuse the behavior when you see a child participating in bullying behavior.
3. Determine the reason that may be provoking the bullying behavior, and help redirect the child to acceptable responses.
4. Do not forget to support the child who is being bullied or is the target of discriminatory behavior. ◇

INCLUSION INSIGHTS

Early Childhood Mental Health Consultation

By C. Melissa Ryan, MSW, Inclusion Specialist

Research continues to emphasize the importance of strong relationships and secure attachments for infants and young children to ensure good social and emotional development. Multiple risk factors such as poverty, family problems including violence or substance abuse, and environmental factors such as dangerous neighborhoods and schools, often compromise the child's development. When a child's social-emotional development has been affected in a negative way, symptoms often show up as behavioral problems. Child care providers are struggling with limited resources and support to care for all children, but especially for those children with behavioral problems.

INCLUSIVE CHILDCARE SERVICES PROJECT

One approach to addressing this issue has been early childhood mental health consultation, an arrangement where a mental health professional (licensed social worker, clinical psychologist, etc.) provides mental health services at a child care center or in the home of a family child care provider. As an example, the High Quality Child Care Mental Health Consultation Program in San Francisco County is a partnership among the San Francisco Starting Points Childhood Interagency Council, the child care community, and two county agencies. The program contracts with eight local agencies that work with child care centers and family child care providers to offer mental health consultation services, and meet regularly with staff to support their efforts to appropriately care for each child.

Several programs across the country and in California have successfully implemented mental health consultation projects. However, there is still no *comprehensive, coordinated* system in California to deliver mental health services to children in child care settings.

Mental health consultation affords the unique opportunity to develop a partnership among the key players—the parent, the child care provider and the mental health professional. It requires a clear understanding of the roles and expectations of each person—especially between the child care provider and the mental health professional, who often have different backgrounds, skills and experiences. A positive and productive experience for each person involved in the collaboration is achieved through a relationship that is respectful, flexible and based on open and ongoing communication. ◆

References:

Mental Health Consultation in Early Childhood, P.J. Donahue, B. Falk, and A. G. Provet. Baltimore, MD: Paul H. Brookes, 2000.

Using Mental Health Strategies to Move the Early Childhood Agenda and Promote School Readiness, J. Knitzer. New York, NY: Carnegie Corporation of New York and the National Center for Children in Poverty, 2000.

Handbook of Infant Mental Health, 2nd Edition, C. H. Zeanah Jr. New York, NY: Guilford Press, 2000.

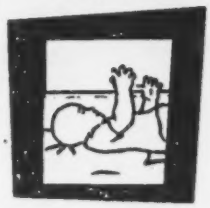
HEALTH CONSULTANT CORNER

Back to Sleep—But Turn to Tummies for Play

by Bonnie Davies, PHN
Child Care Health Consultant,
Colusa County Office of Education/
Children's Services

Since 1992, when the American Academy of Pediatrics first recommended that babies be placed on their backs to sleep, SIDS rates have decreased significantly. This is a victory for SIDS educators—their message to parents and caregivers has been loud and clear.

As child care health consultants we should continue to promote the Back to Sleep message, but we should also encourage parents and caregivers to place infants in a variety of waking positions so they don't spend all their time on their backs. This will prevent flatness on the back of their heads ("positional plagiocephaly"), as well as help them strengthen their neck and shoulder muscles.



There are several ways to vary position:

- Give babies lots of tummy time when they are awake and observed so they can develop all their muscles.
- Put babies to sleep with the head to one side for a week or so, and then change to the other.
- Change the orientation of the bed to outside activities (such as the door of the room) every so often.

Babies who have gotten used to spending most of their time on their

—continued on page 11

HEALTH AND SAFETY CALENDAR

September

National Food Safety Education Month. "Cook It Safely—It's a Matter of Degrees." "Be Cool, Chill Out—Refrigerate Promptly." "Be Smart—Keep Foods Apart." Download posters and food safety tips from the International Food Safety Council at www. restaurant.org/nfsem/, or call (202) 331-5900.

October

6: "Our Children, Our Vision, Our World," Union City. Tri-Cities Children's Centers (510) 744-9280; www.childrensservices.org.

14 - 16: Child Care Resource & Referral Network. (415) 882-0234.

16 - 19: Child Development Division Conference, Ontario. CDD, (916) 322-6233; www.cde.ca.gov/cyfsbranch/child_development.

19 - 20: CA SIDS Program 21st Annual State Conference, San Mateo. CA SIDS Program, (800) 369-SIDS.

19 - 21: California Association for Family Child Care. Santa Clara. Contact Elda Fontenot, fontenotworks@aol.com, (510) 536-9273.

21 - 25: American Public Health Association's 129th Annual Meeting & Exposition. One World: Global Health, Atlanta, GA. Register at www.apha.org/meetings registration.htm, or contact the APHA at (202) 777-2478; edward.shipley @apha.org.

23 - 26: Child Care Food Program Roundtable: Fuel for Early Learning, Palm Springs. CCFP, (925) 686-0522; www.ccfproundtable.org.

18th Annual Training Conference, Region IX Head Start Association, Anaheim. Contact David Flores, (800) 724-6112.

31 - November 3: National Association for the Education of Young Children, Anaheim. NAEYC, (800) 424-2460; www.naeyc.org.

PRODUCT WATCH

Summer Recalls

June 2001

Backyard Gym Set

In cooperation with the U.S. Consumer Product Safety Commission (CPSC), Hedstrom Corp., of Bedford, PA, is recalling for repair about 190,000 **Star Cruiser®** and **Rocket Rider® swings** on backyard gym sets. Screws that hold the swing together can fall out and cause the seat to fall to the ground, posing an injury risk to children. Consumers should stop using the swings immediately and detach them from the gym set. Call Hedstrom toll-free at (800) 642-9[illegible] any time to order a free repair, or write to the company at Hedstrom Corp., Fre[illegible]air Kit, P.O. Box 432, Bedford, PA 15522. A picture of the recalled product(s) can be seen at Hedstrom's Web site at www.cpsc.gov/cpscpub/prerel/prhtml01/01165.html.

Bean-Bag Cushions

Battat Inc. is recalling about 1,500 Parents' magazine-brand **Soft Landing Bean-bag cushions**. Pillows and cushions such as these have been banned under the Federal Hazardous Substances Act since 1992 because they pose a suffocation hazard to infants. In addition, two 8- to 9-inch cords which attach toys to the cushions pose strangulation hazards. Consumers should take the cushions away from children immediately. For more information, call Battat at (800) 247-6144 between 8 a.m. and 5 p.m. ET Monday through Friday, or visit the Battat Web site at www.battat-toys.com.

July 2001

Educational Kits

Advantage Publishers Group, of San Diego, CA, is recalling to replace components in about 160,000 **"Let's Start™ Numbers"** and **"Optical Illusions Lab"** educational kits. The red-painted numbers on the acetate stencil sheet in the "Let's Start™" kit and the gold paint on the black pen included in the "Optical Illusions Kit" contain lead. Customers should call Advantage Publishers Group toll-free at (866) 748-3731 any time to order replacement pieces, or go to the company's Web site at www.advantagebooksonline.com.

High Chairs

Peg Perego USA Inc., of Ft. Wayne, IN, is recalling about 325,000 **high chairs** with 5" armrests. When the seat is reclined, the high chairs have a space between the armrest and backrest in which a child's head or arm can become entrapped. This can pose a risk of suffocation or injury to the heads or arms of young children. Call Peg Perego toll-free at (877) 737-3464 any time or log on to www.perego.com to receive free replacement armrests.

Pre-School Toys

Chicco USA Inc., of Bound Brook, N.J., is recalling about 6,000 **Build-A-Ball** preschool toys. The Build-A-Ball toy consists of five multi-colored and various-sized plastic balls. Some of the larger-sized ball halves can become stuck on a young child's face, covering the nose and mouth, and causing suffocation. For more information, call Chicco toll-free at (866) 242-0643 between 8:30 a.m. and 5:30 p.m. ET Monday through Friday, or visit the company's Web site www.chiccousa.com.◆

LEGISLATIVE UPDATE

Child Care Bills Survive Crises

by Marsha Sherman, Executive Director and Thomas Brennan, Executive Assistant

Crises took their toll on the 2000-2001 legislative session, which wraps up in mid-September. The energy crisis and the budget stalemate both diverted the attention of lawmakers from other issues. One result is that a higher-than-normal number of bills became "two-year bills," meaning that consideration of those bills has been postponed until the 2001-2002 session. Among them are **AB 383** (Chan), Child Care Health Linkages; and **SB 681** (Figueroa), Child Care Workers: Health Care Coverage.

As we went to press, the legislature was still considering **SB 248**, which would push California's existing school readiness programs to new levels of scope and accountability. Introduced by Senator Deborah Ortiz (D-Sacramento), SB 248 would require school readiness programs to become accredited by the California Department of Education (CDE) in order to continue receiving funds. For more information, contact Senator Ortiz at State Capitol, Room 5114, Sacramento, CA 95814, or visit her Web site at http://democrats.sen.ca.gov/senator/ortiz.

Another bill under consideration is **AB 1634** (Chan), Child Care Diversity Training. Cosponsored by Assemblywoman Wilma Chan (D-Oakland, Alameda, Piedmont) and Lieutenant Governor Cruz Bustamente, AB 1634 would require the formation of a task force to develop tools to enhance child care providers' ability to serve California's diverse communities. The task force would be charged with identifying best practices and developing standards and curricula. The curricula would also teach providers to work effectively with diverse families and help young children respect diversity. For more information, contact Assemblywoman Chan at State Capitol, Room 4098, Sacramento, CA 94249-0001, or visit her Web site at http://democrats.assembly.ca.gov/members/a16.◆

—Back to Sleep—But Turn to Tummies for Play, continued from page 9

backs—playing, sleeping, riding in car seats—can become very fussy when placed on their tummies. Encourage parents and caregivers to make tummy time interesting, pleasant, full of interactions and frequent.

Minor deformities will usually correct themselves. Between the ages of three and 12 months is the best time for assessment and intervention. If parents are concerned about their child's head shape, encourage them to speak to their pediatrician. For more information, call the Healthline at (800) 333-3212. ◆

References:

DOC Bands: Reshaping the Future, Tabor. Raising Arizona Kids, Vol. 9, Number 4, (1998).

Importance of Early Recognition and Treatment of Deformational Plagiocephaly with Orthotic Cranioplasty, Kelly et al. The Cleft Palate-Craniofacial Journal, Volume 36, Number 2, March 1999.

Varying Position Reduces Head Molding, Clark. American Academy of Pediatric News, Volume 12, Number 4.

—Communicable Illnesses and Child Care, continued from page 4

other objects in their mouths, and many have not yet learned proper use of the toilet, or the importance of handwashing, increasing their exposure to common germs.

Child care providers can play a very important role in keeping germs from spreading in the child care setting. Having clear health and safety policies, doing daily health checks, following proper handwashing, diapering, food safety, and environmental cleaning and sanitation procedures, helping keep immunizations up-to-date, and communicating with child care health consultants, parents and health care providers will help you to achieve your goal. ◆

Health and Safety in the Child Care Setting:

Prevention of Infectious Disease

(Module I)

A Curriculum for the Training of Child Care Providers (Revised Edition 2001)

This updated 2001 edition covers the content of EMSA's 7-hour Child Care Preventive Health and Safety Training. It provides information and guidance on how to control communicable and infectious diseases in the child care setting.

Cost is $25 per copy including shipping. Request an order form by calling (619) 594-3728, emailing weather1@mail.sdsu.edu, or faxing (619) 594-3377. Please send a check with the order form payable to SDSU Foundation, or mail/fax your purchase order to: CCHP, 6505 Alvarado Road #108, San Diego, CA 92120.

Resources

Products, books, furniture and posters described in this Resources section are brought to your attention so that you can see what is available. ***Child Care Health Connections*** does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and Materials

After-School Care for Children: Challenges for California finds that half of California's eligible working families do not have after-school care, despite the proven benefits of after-school programs. Free. Children Now, (510) 763-2444; online at www.childrennow.org.

Financing Child Care in the United States is an expanded catalog of strategies used around the U.S. to generate and allocate public revenue for child care, to finance care in the private sector, and to build public-private partnerships. Free. Ewing Marion Kauffman Foundation, (816) 932-1000; online at www.emkf.org.

Healthy Families: Family Health Insurance Through One Door offers recommendations for creating a unified health insurance program for children and their parents in California. Free. 100% Campaign, (510) 763-2444; online at www.100percentcampaign.org.

Online Resources

The Danny Foundation, 1-800-83DANNY or www.dannyfoundation.org/ for information on safe cribs and Sudden Infant Death Syndrome.

CCHP Web Site Undergoes a Makeover

CCHP's Web site has a new look, is more user-friendly than ever, and has several new as well as familiar features including the current newsletter, current CCHP projects, seasonal topics, training curricula, Health Consultant Corner, Health & Safety Notes, a glossary of terms, and expanded resources and links. Check us out at www.childcarehealth.org. ◆

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CALIFORNIA CHILDCARE HEALTH PROGRAM

Child Care Health Connections

A health and safety newsletter for California child care professionals

Published by the California Childcare Health Program
Graduate School of Public Health, San Diego State University

November-December 2001 ◦ Volume 14 ◦ Number 6

Changes

We are very pleased to announce that the California Childcare Health Program (CCHP) is on the move. Effective September 1, 2001 the Child Care Health Linkages Project changed its grantee agency from SDSU to the University of California San Francisco (UCSF), School of Nursing Department of Family Health Care Nursing. The California Commission for Families and Children will continue to fund CCHLP. The continuation award will be under the direction of the UCSF School of Nursing with Abbey Alkon, PhD as the principal investigator. CCHP would like to move all their projects to UCSF, and negotiations are under way for UCSF to apply for the continuation of these grants. Although UCSF may be the future grantee of our projects, CCHP will maintain its present location in Oakland. We will keep you up to date via the newsletter.

The Safely on The Move Project, which focuses on child passenger safety in child care will remain with SDSU, and will no longer be a part of CCHP effective October 1, 2001.

Contact information for each project will remain the same, as well as our strong commitment to enhancing the quality of child care in California.

As before, you may contact us at:

California Childcare Health Program
1322 Webster Street, Suite 402
Oakland, CA 94612-3218
(510) 839-1195

PS 029880

Caring for Ourselves

by Eva Guralnick

How are *you* feeling today?

The terrible events of September 11 have left many of us feeling shaky, numb and bewildered. It can be particularly hard to cope with these feelings at work—and as child care providers, it's hard to take time off when parents need our help. In this issue of *Child Care Health Connections* we have included a Health and Safety Note on children and disasters to help you cope with children's feelings, and you'll find further information on our Web site at www.childcarehealth.org. But your health and well-being are just as important; you cannot help others if you don't take care of yourself.

We all react to stressful incidents differently. By the time you read this, you may be feeling back to normal. But you may still be feeling anxious, numb, irritable, depressed or moody. Physically, you may be having headaches, nausea or other stomach problems, fatigue, muscle aches or frequent colds. You may be having trouble concentrating, feel confused or forgetful, or find yourself withdrawing from the people and activities you formerly enjoyed. These feelings and symptoms are normal, but if they persist in intensity for more than six weeks, consider seeking professional counseling. If you are having trouble getting up for work, are losing weight or sleep, or have any symptoms of severe depression, you should seek help much sooner.

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Child Care Health Connections©

Child Care Health Connections is a bimonthly newsletter published by the California Childcare Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Childcare Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of **Child Care Health Connections** are published during the year in odd-numbered months at the subscription rate of $20 per year.

Newsletter articles may be reprinted without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Childcare Health Program at the San Diego address below.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit us on the Web:
www.childcarehealth.org

ASK THE NURSE...

Seasonal Allergies

by Tram Trinh, RN, MSN, Child Care Healthline Coordinator

Q: Fall and winter are coming. Should I have any special concerns regarding seasonal allergies and the children I care for?

A: Fall and winter are upon us, and special precautions can be taken. Pollen season may be about over, but the emergence of mold spores should be recognized and not ignored, and dust never really goes away. Children are more at risk for frequent upper respiratory infections and eczema during these months. Special attention to children with asthma is needed because of the increase in mold spores due to dampness from rain and seasonal climate changes, possibly dramatic temperature changes, and increased exposure to indoor triggers, such as cockroach droppings, pet dander and dust mites.

Here are my recommendations for child care providers and parents to help make fall and winter safer and more comfortable for children:

- Keep the humidity in your center or home below 35 to 50 percent by using exhaust fans while cooking or taking showers. Increased humidity is a breeding ground for mold, which aggravates allergies in some children.
- Keep children from playing outdoors in areas where mold likes to grow, such as dark, wooded areas.
- Try to avoid carpets and rugs in sleeping areas, upholstered furniture and bedding. Dust mites and mold can multiply in rugs and carpets because dampness accumulates between the pad and carpet.
- Providers with pets should take note that due to the colder fall and winter weather, animals are forced to spend more time indoors, which can increase pet dander and allergy symptoms in children with allergies.
- Providers and children with asthma should get an annual flu shot. Children and providers are more susceptible to viral respiratory infections, such as the flu or the common cold.
- Providers should wash their hands frequently to avoid exposure to germs that could be spread to children.
- Wash linens weekly and other bedding such as blankets every two to three weeks in hot water. Then dry them on the hottest clothes dryer cycle. Choose blankets and pillows made of synthetic materials.

There is no way to avoid all allergy triggers, but providers can greatly assist children by altering the child care and play environment while children are in your care. ◆

References:

www.aafa.org/asthmaandallergyinformation/aboutasthmaandalle.../Holiday Allergies.cf
www.nycornell.org/news/press/1998/allergies.html
http://healthandenergy.com/winter_allergies.htm
http: file://www.njc.org/news/winter1.htm1

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INFANT/TODDLER CARE

How to Discuss War and Terrorism with Young Children

by Cheryl Oku, Infant-Toddler Specialist

Your children have certainly heard about the tragedy of September 11, 2001 and the ongoing "war on terrorism." Here is some guidance for those concerned about how recent news will affect children who hear about these events in the news media or in conversation.

Young children are most concerned about themselves and the ones they love, and take their cues from people who care about them. They need to be reassured that their family and loved ones are okay and that you will keep them safe. If they ask questions or seem upset, don't cover up what has happened. You can say something simple such as: "Bad people hurt other people and we don't like it."

You can protect children by making sure they are not exposed to information they cannot handle. This means turning off the TV or radio news, not leaving newspapers and magazines around, and asking other adults and older children not to discuss events with very young children.

Children need to feel you're in control, but it's okay to cry, to be upset, or even angry. Let them know they are not the cause of your out-of-the-ordinary feelings and emotions.

Remember that children of different ages will react differently to what is happening around them.

> ***One-year-olds*** are upset when you're upset. They most likely will not know about or be able to understand what has happened. However, they may react to your tension, fear or pain. They may be more clingy or irritable, requiring extra patience from parents and other caregivers. Be reassuring.
>
> ***Two-year-olds*** have a concept of hurt. They will pick up on people being hurt—point out that there are lots of people helping those who are hurt. Reassure them that you will keep them safe.
>
> ***Three-year-olds*** will have more understanding of what they see on the news and will wonder if it's real. You might say, "Yes, it's real—but we're okay." Repeat confidently that you're safe and they, too, will be safe. Don't be surprised if they talk about it over and over again or reenact what they saw—just continue to reassure them. Children as young as two might express fear about airplanes, helicopters, sirens, etc.—again, be reassuring.

Create a comfort zone for yourself and your children. Do what's comforting to you and your own family—for example, cuddling up together, singing, lighting candles or praying. Keep up your normal routines and create stability. ◇

Adapted from a Zero to Three press release.

The Infant/Toddler Child Care & Health Project is funded by the Quality Improvement Program, Child Development Division, California Department of Education.

NUTRITION

Infant Calcium and Vitamin D Needs

by Sue Jensen, RN, MSN, PNP

During infancy, childhood and adolescence, bone growth is rapid. Calcium intake during these periods contributes to bone strength in adulthood. We know that calcium builds strong bones and teeth. What isn't commonly known is that vitamin D helps the body use the calcium in our diet so it won't be pulled out of the bones.

Insufficient vitamin D in infant and toddler diets can lead to a condition called "rickets," where the bones soften, and can bend and break. Rickets is easily preventable and usually curable. At risk are infants who have limited or no sources of vitamin D in their diet. Other risk factors include dark skin color and milk and soy allergies.

The body cannot manufacture calcium, but it can make vitamin D when the skin is exposed to sunlight (sun exposure is not recommended as a source of vitamin D in infants). The primary sources of calcium in infants are breast milk and formula. All formulas (including soy) are fortified with calcium and vitamin D. Breast milk provides calcium but does not contain vitamin D. This is why the American Academy of Pediatrics recommends that babies who are breastfed (no formula) receive a vitamin D supplement.

In toddlers, vitamin D is supplied by fortified dairy and soy products, fish oils, fortified margarine and egg yolks. Sources of calcium are fortified dairy and soy products, calcium-fortified juice, sardines and vegetables such as broccoli and spinach. Read nutrition labels on foods to check for vitamin D.

If a parent is breastfeeding only and is

—continued on page 11

Personal Responsibility and Compassion: World AIDS Day

by Lyn Dailey, PHN

December 1, 2001 is World AIDS Day, a day for messages of compassion, hope, solidarity and understanding about AIDS to every country in the world. In 2000, 196 pediatric AIDS cases were reported in the United States, and an estimated 3,622 children less than 13 years of age live with AIDS in the U.S. HIV (the virus that causes AIDS) infection ranks seventh among the leading causes of death for U.S. children one to14 years of age. Child care programs can respond to this public health threat by helping children, staff and families protect themselves from infection, and by teaching compassion and inclusion for those who are infected with or disabled by HIV.

Personal Responsibility

Teach young children to seek out a caregiver when they or someone else is bleeding. They can learn not to touch another person's wound, to wash their hands immediately if they do come into contact with blood, and to dispose of tissues and bandages that contain blood. Children also should learn about personal hygiene and develop other healthy habits. Teaching children about "germs" and the different ways they are spread will help protect them from many diseases.

Parents and staff must take responsibility for keeping children and themselves home when their health poses a danger to others. HIV infection or AIDS is not a danger to others in the child care setting unless there is exposure to another's blood, but HIV-infected people may be at serious risk if they attend child care with children or staff who have certain infections.

Compassion

Staff must be prepared to work with parents or caregivers of infected children and to respect their treatment decisions. Health is a highly personal issue and not everyone responds in the same way to illness. Some parents or caregivers may not want to disclose a child's HIV status, or HIV-positive mothers may continue to breastfeed their babies. Parents and caregivers must make many decisions about their child's treatments and care. Exercise compassion by supporting these decisions and providing the best care possible for the child. Children with HIV infection or AIDS may have siblings who are also infected, and may have lost one or both parents to AIDS. Partner with the child's caregivers to access the support a child might need. Be sensitive to the diversity of families.

Children learn compassion when programs practice inclusive care. Children with special health needs or disabilities of all types may require you to seek ways to individualize your care to promote inclusion. All children can benefit from learning compassion for individual needs.

Most importantly, get more information about HIV and AIDS. Protect yourself personally and professionally by practicing universal precautions with all blood and body fluids that contain blood. Learn what behaviors place you at risk and teach others. ◆

Source: http://www.avert.org/worldaid.htm

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Candy Poses Choking Hazard

by Robert Frank, MS,
Linkages Technical Assistant

Child care workers and parents should be on the lookout for jelly candy that poses a choking hazard to children, according to the U.S. Federal Drug Administration. On October 5, 2001, the FDA announced it had banned imports of the candy because it poses a serious choking risk, particularly to infants, children and the elderly. Three children in the United States have died after choking on the candy, and deaths have been reported in other countries as well.

The candy is sold under various names, including "Fruit Poppers," "Jelly Yum," "Gelly Drop," "Lychee Flavor Mini Gel Snack" and "Conjac Coconut." Packed in small plastic cups, it is made with conjac jelly, which does not quickly dissolve in the mouth. Some are labeled as inappropriate for children of various ages; others have no warning label.

Some supermarkets pulled this candy from their shelves in August when the FDA began its investigation. However, the FDA warns that the candy may still be in the marketplace. To make sure that the children in your program do not eat it, take the following steps:

- Distribute this alert to staff and parents immediately.
- Do not allow this type of candy to be consumed in your program—remember that children might bring it in their lunches or as treats on special occasions.
- Discuss at next parent meeting.◆

Sources:
U.S. Food and Drug Administration Talk Paper T01-38, August 17, 2001.

FDA Press Release P01-17, October 5, 2001.

How Do Medications and Food Interact?

by Rahman Zamani, Program Specialist

What is a medication-food interaction?

Food is necessary for life, and medications are important for treatment of many health problems. However, when mixed together they may combine in a way that either makes the medication less effective or keeps important nutrients from being used by the body. Drug and food interactions can happen with both prescription and non-prescription (or over-the-counter) medications such as widely used antacids, vitamins and iron pills.

Are all medications affected by the food we eat?

No, but many can be affected not only by what we eat, but also by when we eat. To ensure that medications are safe and effective, carefully follow your health provider's and pharmacist's instructions.

How do drugs and food interact?

Certain foods, beverages, alcohol, caffeine and even cigarettes can interact with medications. Many individual factors such as dose, age, weight, gender and overall health may influence their effectiveness.

Some foods may decrease the absorption of medication. Tetracycline is a good example of a group of related antibiotics that are labled "cyclines," and whose absorption is significantly inhibited by milk and dairy products. Other medications which treat mild to moderate pain and fever, such as acetaminophen, are better absorbed if taken on an empty stomach.

Some foods may also increase the absorption of medication. Orange juice is a good example of food rich in vitamin C, which helps the body absorb more iron. Alcohol increases drowsiness and slows mental and motor performance if taken with antihistamines, medications used to relieve or prevent the symptoms of cold and allergies.

Some drugs may increase or decrease appetite. For example, drugs used in the treatment of cancer frequently cause nausea and vomiting; and insulin, steroids and certain antihistamines can cause a person to feel hungrier than normal.

Some drugs interfere with the absorption of important nutrients in food. For example, mineral oil used for constipation prevents absorption of fat-soluble vitamins A, D, E and K.

Some medications can irritate the stomach, so it is best to take them with food or milk.

Remember: Not only can medications interact with food and alcohol, they can also interact with each other.

Tips to remember about medication-food interactions

- Make sure your health care provider knows about every medication you take regularly or occasionally including over-the-counter ones.
- Read directions, warnings and interaction precautions printed on all medication labels and packages including over-the-counter remedies. If you need more information ask your health care provider or pharmacist.
- Follow directions and take medication as prescribed.
- Take medicine with a full glass of water.
- Do not mix medication with food or take capsules apart unless told to do so by your health care provider.
- Do not take vitamin pills at the same time you take medications, because vitamins and minerals can interact with some drugs.
- Never take medication with hot drinks because the heat may destroy its effectiveness.
- Never take medication with alcohol.
- If your child attends child care or school, discuss ways of reducing the number of medications and doses with your health care provider. ◇

Sources:

Food and Drug Interactions. A brochure by the U.S. Food and Drug Administration (FDA) and the National Consumers League, 1998: http://vm.cfsan.fda.gov/~lrd/fdinter.html.

Medicine and Food: Do They Mix? A brief information page by the American Academy of Family Physicians, April 1995.

Aging and Nutrition. Essay features information on necessary nutrients, food and drug interaction, and modifying foods for easier consumption by the elderly.

CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes
California Childcare Health Program

Young Children and Disasters

CHILDCARE HEALTHLINE

Disasters and Trauma

After experiencing a disaster—whether it is a flood, earthquake, fire, hurricane or bombing—children may react in ways that are difficult to understand. Even if you or your child were not physically injured, the emotional response can be strong. They may act clingy, irritable or distant, and although they are very young and do not seem to understand what is going on, they are affected as much as adults. Adult fears and anxieties are communicated to children in many ways. The experience is more difficult for them, as they do not understand the connection between the disaster and all the upheaval that follows. They need reassurance that everything is all right.

There is a wide range of "normal" reactions for children following a disaster, most of which can be handled with extra support at home, child care and school. In some cases, professional intervention may be needed, despite everyone's best efforts. Early intervention can help a child avoid more severe problems.

Message to Parents

Some ways to provide reassurance after a disaster are:

- Try to remain calm.
- Remember the effect and anxiety produced by watching television coverage or listening to the radio. Keep TV/radio/adult conversations about the disaster at a minimum around young children.
- Spend extra time being close to your child(ren).
- Answer all questions as honestly and simply as possible. Be prepared to answer the same questions over and over. Children need reassurance to master their fears.
- Spend extra time with your child at bedtime—soothing and relaxing time—talking, reading or singing quietly.
- Spend extra time with your child when bringing them to child care—they may be afraid you will not come back.
- Try to return to a normal routine as soon as possible to restore a sense of normalcy and security.
- Don't promise there won't be another disaster. Instead, encourage children to talk about their fears and what they can do to help in case of disaster. Tell them you will do everything you can to keep them safe.
- Be patient and understanding if your child is having difficulties.
- Never use threats. Saying, "If you don't behave an earthquake will swallow you up," will only add to the fear and not help your child behave more acceptably.
- Consider how you and your child can help. Children are better able to regain their sense of security if they can help in some way.
- Share your concerns with your child's teacher or child care provider. Consider assistance from professionals trained to work with disaster victims.

Message to Child Care Providers

You can be a support and resource to parents by helping them understand behavioral and emotional responses. Be sensitive to how parents feel when they are separated from their children in a disaster. It may be very helpful for parents, children and you to take some extra time when dropping off children in the morning. A group meeting to reassure parents, discuss your response to their children's reactions, and review your emergency plan will help everyone feel more secure.

Help children cope by reenacting how the disaster felt and talking about their fears so they can master them. Talk about being afraid, and practice what you will do the next time a disaster strikes. Because young children think the world revolves around them, children may need reassurance that they did not cause the disaster.

Consider referring a family for professional help if any of the behaviors on the following page persists two to four weeks after the disaster. Children who have lost family members or friends, or who were physically injured or felt they were in life-threatening danger, are at special risk for emotional disturbance. Children who have been in previous disasters or who are involved in a family crisis may also have more difficulty coping.

Typical Reactions of Children Following Disaster

Children Ages 1 to 5

Children in this age group are particularly vulnerable to changes in their routines and disruption of their environments. Dependent on family members for comfort, they may be affected as much by the reactions of family members as by the disaster. Focus on reestablishing comforting routines, providing opportunity for nonverbal and verbal expression of feelings, and reassurance.

Regressive Reactions

- Bedwetting
- Thumbsucking
- Fear of darkness
- Fear of animals
- Fear of "monsters"
- Fear of strangers

Emotional/Behavioral Reactions

- Nervousness
- Irritability
- Disobedience
- Hyperactivity
- Tics
- Speech difficulties
- Anxiety about separation from parents
- Shorter attention span
- Aggressive behavior
- Exaggeration or distortion of disaster experience
- Repetitive talking about experiences
- Exaggeration of behavior problems

Physiological Reactions

- Loss of appetite
- Overeating
- Indigestion
- Vomiting
- Bowel or bladder problems
- Sleep disorders and nightmares

How to Help

- Give additional verbal assurance and ample physical comforting.
- Provide comforting bedtime routines.
- Permit the child to sleep in the parents' room on a temporary basis.
- Encourage expression of emotions through play activities including drawing, dramatic play, or telling stories about the experience.
- Resume normal routines as soon as possible.

Children Ages 5 to 11

Regressive behaviors are especially common in this age group. Children may become more withdrawn or more aggressive. They might be particularly affected by the loss of prized objects or pets. Encourage verbalization and play enactment of their experiences. While routines might be temporarily relaxed, the goal should be to resume normal routines as soon possible.

Regressive Reactions

- Increased competition with younger siblings
- Excessive clinging
- Crying or whimpering
- Wanting to be fed or dressed
- Engaging in habits they had previously given up

Emotional/Behavioral Reactions

- School phobia
- Withdrawal from play group and friends
- Withdrawal from family contacts
- Irritability
- Disobedience
- Fear of wind, rain, etc.
- Inability to concentrate and drop in level of school achievement
- Aggressive behavior
- Repetitive talking about their experiences
- Sadness over losses
- Overreaction to crises or changes in the environment

Physiological Reactions

- Headaches
- Complaints of visual or hearing problems
- Persistent itching and scratching
- Nausea
- Sleep disturbance, nightmares, night terrors

How to Help

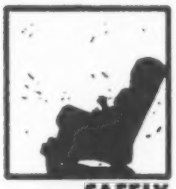
- Give additional attention and ample physical comforting.
- Insist gently but firmly that the child accept more responsibility than younger siblings; positively reinforce age-appropriate behavior.
- Reduce pressure on the child to perform at his or her best in school and while doing chores at home.
- Reassure the child that his competence will return.
- Provide structured but not demanding chores and responsibilities.
- Encourage physical activity.
- Encourage verbal and written expression of thoughts and feelings about the disaster; encourage the child to grieve the loss of pets or toys.
- Schedule play sessions with adults and peers.

Also available in Spanish. See the order form, or contact CCHP's San Diego office at weather1@mail.sdsu.edu or (619) 594-3728. Revised September 2001

Keep Children Safe in and Around Vehicles

by Sara B. Woo, MPH, Project Coordinator, Safely on the Move

With the onset of the holiday season, we need to be especially careful about keeping children safe in and around vehicles. There are lots of distractions, traffic is heavier and weather can be a complication. Parents and providers need to be especially focused on keeping safe around traffic and assure children are never left alone in a car, even for a quick run into a store or child care.



Leaving children unattended can be very dangerous. In the last five years alone, 275 children have died after being left alone in or around vehicles, 43 in California. Even with the windows left partly open and temperatures in the 60s, heat stroke can lead to permanent brain damage or death in a matter of minutes.

Child care providers can:

- Tell parents about the dangers of leaving children alone in or around vehicles.
- Post a Kids 'N Cars poster. (Go to www.kidsncars.org)
- Keep car keys out of reach of children and keep vehicles locked, even in the driveway and garage.
- Create written policies to call the parent if children expected at child care are not dropped off within one to two hours of their expected arrival time. Ask parents to contact you if a child will not be attending child care as normally scheduled.
- Ensure that children are not left unattended in vehicles by parents during drop-off or pick-up times.
- Review and enforce "roll call" policies before, during and after outings with children to be sure no one is left behind.

California has recently adopted a state law (SB255) to outlaw leaving children unattended in a vehicle. If a child from birth to six years is left unattended in the vehicle, the responsible adult will be fined $100. Nine states have already adopted laws regarding not leaving children unattended in motor vehicles.

Contact Kids 'N Cars via their Web site at www.kidsncars.org or call the Healthline at (800) 333-1212 for more information about this issue. ◇

The Importance of Culturally Competent Child Care

by Veronica Keiffer, Diversity Specialist

Cultural competence in child care has become even more urgent since the terrorist acts of September 11, 2001. Such acts are called "terrorism" precisely because they generate fear, and deep fear can cause people—adults and children—to behave differently than normal. Sometimes fear has caused even those who don't consider themselves racist to blame entire ethnic groups rather than the individuals actually responsible for the acts.

Children feel the fear around them, even if they are too young to understand, and it affects their behavior also. They may become unusually aggressive, and this aggression can be influenced by adult behaviors they see. Diversity experts agree that children learn stereotypes and biases from television, peers, parents and teachers.

How can you promote tolerance among the children in your care? First, recognize that you are not immune to assumptions, suspicion and prejudice. Most of us learned prejudices growing up and hopefully we are working to unlearn them. Beliefs are not behaviors, however, and regardless of our beliefs our behaviors can model tolerance, patience and compassion.

Second, if you observe bias-based aggression among children, confront those biases and behaviors. Here are three steps for preventing and managing such behaviors, and sending a clear message of tolerance: **1. Set limits:** make a rule that it is never acceptable to reject or tease someone because of their identity or appearance. **2. Intervene immediately** and remind the children of the rule. **3. Comfort and support** the target of the aggression, and help the target child verbalize her or his feelings to the other child: "I don't want you to do that—it hurts my feelings."

For information:
Bay Area Network for Diversity Training in Early Childhood (BANDTEC): (510) 658-9197; Southern Poverty Law Center's Web-based program: www.tolerance.org. ◆

INCLUSION INSIGHTS

Answering Children's Questions About Disabilities

by C. Melissa Ryan, MSW

As every child care provider knows, children are curious about the world around them. If you are a child care provider who has children with disabilities or other special needs in your care, then you have likely answered questions about a child with disabilities. Though these questions may feel awkward, they also present an opportunity to help children understand similarities and differences among children.

INCLUSIVE CHILDCARE SERVICES PROJECT

Children's questions about disabilities are usually straightforward. Try to answer these questions in a truthful, informative and sensitive manner. For example, a child may ask, "Why doesn't Caitlin talk?" or comment, "I can run faster than he can." In response, a child care provider can demonstrate to the child how Caitlin talks with her eyes or her smile. When a child makes remarks about how s/he is stronger or faster than another child, one answer could be that some of us move fast and some of us move slowly. Remember, it is natural for children to ask questions, including questions about disabilities, and how you address these questions can help build a better inclusive program.

Tips for Answering Children's Questions About Disabilities

- Your attitude, body language or tone of voice may be what the children will imitate. Convey an open and positive attitude when you answer questions about disabilities.
- Answer what the children ask, but be brief.
- Listen for the feelings behind a child's questions and talk about them. Let a child know that it is okay to express fears or any other feeling.
- Use simple words and examples the child can understand.
- Look for opportunities to show how children with and without disabilities are different and the same.
- Do not criticize the child's comments or questions.
- Give the child your undivided attention and notice his or her response to your answer. Listen to see if there are follow-up questions.
- Whenever appropriate, encourage other children to ask their questions directly to the child with disabilities. ◆

Sources:
We're in This Together. L. Lewis. Des Moines, Iowa: Iowa Department of Education, Bureau of Special Education (1989).
Circle of Inclusion Project. University of Kansas (1999).

Resource:
www.circleofinclusion.org

HEALTH CONSULTANTS

School Readiness

by Diana Harlick, Technical Assistant, Child Care Health Linkages Project

National and state early childhood initiatives are placing increased emphasis on achieving school readiness. School readiness targets children ages 0-5 to help them to succeed in a more rigorous academic environment. Research shows us that quality early childhood programs have a positive impact on life-long achievement. Supported by research on the positive impact of quality early childhood programs on lifelong achievement, policymakers are now encouraging educators and the child care community in particular to develop programs that prepare young children for school.

Getting involved in school readiness initiatives is a natural extension of the work of Child Care Health Consultants. A healthy child can learn more effectively than an unhealthy one. School readiness seeks to bring together parents, early childhood development educators, health and social service professionals, policymakers, and maternal and child health to address all elements of child and family development. Health Consultants already support these efforts by the linkages they create between the child development and public health fields. For example, encouraging child care providers to create and implement special care plans for children with chronic health needs such as asthma or allergies will contribute to a child's school readiness. If the child care provider encourages parents to take copies of the special care plan to school, the transition from child care to school will be much safer and secure for the child, the family, and for school staff.

Child care health consultants must become adept at identifying and clearly

—continued on page 11

EVENTS

November

Nov. 1-3: LDA-CA 2001 State Conference. Concord. Learning Disabilities Association of California, (916) 725-7881; www.LDACA.org

Nov. 7-9: 10th Annual California Association of Nonprofits Conference—Building Better Nonprofit Tools for Success. San Francisco. CAN, (213) 347-2070 or visit www.CAnonprofits.org

Nov. 9-10: Early Childhood, Families, and Welfare Reform. Berkeley. Professional Association for Childhood Education Conference, (510) 642-7223

Nov. 13: Inter-Agency Council on Child Abuse and Neglect Nexus VI Conference. Los Angeles. ICAN, (626) 455-4585

Nov. 14-17: 2001 TASH Conference. Anaheim. TASH-Disability Advocacy Worldwide, (800) 482-8274; www.tash.org

Nov. 30- Dec. 2: ZERO TO THREE National Training Institute. ZERO TO THREE/National Center for Infants, Toddlers, and Families, (202) 624-1760; www.zerotothree.org

January

January 10-12, 2002 California School-Age Consortium. CalSAC's Second Annual Statewide Middle School Conference, Miyako Hotel, San Francisco, California. (415) 957.9775, www.calsac.org

PRODUCT WATCH

Infant Walkers

by Sara Evinger

Recent headlines about children injured in walkers remind us that we all have more educating to do on this subject. In spite of Community Care Licensing's ban on walkers in child care and admonitions in the press about accidents, injuries and even deaths, walkers are still widely in use. An estimated 8,800 children younger than 15 months were treated in U.S. hospital emergency departments in 1999 alone. Most of these injuries were related to falls, many involving stairs. The most common injury seen with walker use is head injury due to falls down stairs or tipping over. Walkers may tip over on uneven floors, carpet edges or raised thresholds. Skull fractures commonly result from walker falls. Burns have resulted from babies in walkers reaching and grasping cords of hot appliances or containers of hot liquids.

Some parents say that walkers keep infants quiet and happy, encourage mobility, promote walking and exercise, and hold the infant during meals. But there is no evidence that babies who use walkers learn to walk earlier, as they use different muscles in walkers. Since infants can get around in a walker, they do not have an incentive to crawl or walk, so walkers may even delay the onset of walking.

For more information, contact the Healthline at (800) 333-3212.

Adapted from: Andrew Baumel, MD, FAAP, Framingham Pediatrics, Framingham, MA

Sources:
American Academy of Pediatrics, www.medem.com
Consumer Product Safety Commission, www.cpsc.gov

Consumer Product Safety Commission Recalls

Butterfly Baby Toys Kids II, of Alpharetta, GA is recalling 21,000 Carter's butterfly baby toys which can cut or scratch. Remove from babies immediately; return to place of purchase or contact Kids II for free replacement: (877) 325-7056 or www.kidsii.com.

Children's Toy Toolboxes Racing Champions Ertl Inc. (RCE), of Dyersville, IA, is recalling 11,600 John Deere Kids Toolboxes. The handle can break, creating small parts and a sharp edge, posing a choking/laceration hazard to young children. Remove from young children immediately. Contact RCE at (866) 898-4999 for free replacement.

Children's Toys STK International, of Los Angeles, CA, is recalling 110,000 children's toys which can break, causing small balls to be released, posing a choking hazard to young children. They include: Two-piece Tambourine Set, Bathtime Water Wheel, Funny Loco Wind-Up, Pull Back Duck in Boat. Remove toys from children immediately. Call STK International at (800) 536-7855 for information on full refund.

"Kids Meal" Toys Burger King Corporation, of Miami, FL, and Alcone Marketing Group, of Irvine, CA, are recalling 2.6 million "Hourglass Space Sprout" and "Look for Me Bumblebee" toys which can break, causing small beads or balls to be released, posing a choking/aspiration hazard to young children. The toys were distributed in Burger King Kids Meals for children under three years old. Remove toys from children and call (800) 661-9173 or visit www.burgerking.com for a free replacement. ◇

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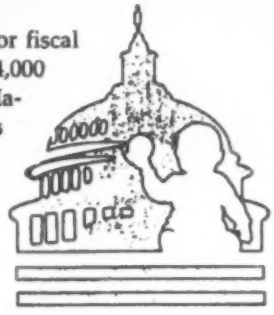
LEGISLATIVE UPDATE

Funding: Good News and Bad News

by Thomas Brennan

In a perfect world we would devote all of our attention to delivering the highest quality care for our children. In the real world, unfortunately, we are distracted by dozens of details just to keep child care centers and homes running. One of the biggest distractions has to be money. This distraction appears to trouble lawmakers in Sacramento, too; the state budget seems to be an ever-changing document. In an effort to help sort it out, we'll start with the bad news.



At our deadline (mid-September), the state budget for fiscal year 2001-2002, as enacted, would cut the entire $2,644,000 allocation of state General Fund moneys for county Maternal and Child Health (MCH) services. Worse, the cuts would mean the loss of federal matching funds. The child care community responded quickly and worked with Assemblywoman Helen Thompson (D, Yolo, Solano, and parts of Sacramento counties) to introduce legislation (AB 1147, County Maternal and Child Health Services: Funding) to restore the funding.

AB 1147 could turn this situation around, assuming it passes both houses and is not vetoed by Governor Davis. For an update, visit Assemblywoman Thompson's Web site at http://democrats.assembly.ca.gov/members/a08.

The good news is that the state budget also includes a $150 million expansion of the Healthy Families Program (HFP). This could increase enrollment in HFP by 250,000 individuals because it broadens eligibility to include parents with incomes up to 250 percent of the Federal Poverty Level (previously capped at 200 percent).

Ironically, this could become bad news if the federal government declines to participate. The Health Care Financing Administration (HFCA), the agency overseeing the federal State Children's Health Insurance Program (SCHIP), must approve California's plan before it can go into effect. For more information visit www.dhs.cahwnet.gov/director/healthy_families. ◆

– Infant Calcium and Vitamin D Needs, continued from page 3

not using any formula), CCHP advises her to consult her health care provider about giving baby a vitamin D supplement. (Reassure her this does not mean she has to give formula.) Infants can start small amounts of yogurt, cottage cheese, or vitamin D-fortified soy foods at about seven months of age. For toddlers, advise parents to check the labels carefully to make sure the product is fortified. Unfortified soy products may be contributing to the increase in cases of childhood rickets.

Sources:
Caring for Your School-Aged Child: Ages 5-12. Bantam (1999).
Pediatrics Vol.104, No. 5, November 1999, p. 1152-1157

– Caring for Ourselves, continued from page 1

Therapist Patricia Ross, MFT recommends talking to the children in our care about the disaster without dwelling on it. "It's really essential to limit the exposure of children to television images and discussion about the disaster, because our anxiety is conveyed to them whether we want it to be or not," she said. "It's absolutely fine to explain to children that you're sad, but small children can't grasp this terrible event fully. Acknowledge your feelings without burdening the children. You don't want them to feel that they have to take care of you."

Although working with children brings unique stresses during difficult times, it also has its benefits. "I think one of the most important things we can do to feel better is to be in the present, and that's where children are," said Ross. "That's why working with children can be very healing for us, too." ◇

Reference:
Common Reactions to Critical Incidents, Barbara Blasdel, PhD, Northern California Society for Psychoanalytic Psychology, 2001.

– School Readiness, continued from page 9

communicating the health and safety aspects of all quality and school readiness initiatives in their community. This means participating in meetings and joining coalitions that address these issues. Some important groups to link with include your local Child Care Planning Council, Child Development Training Consortia, Mentor Teachers, CARES initiatives, child care directors' groups and Family Child Care Associations, school districts and after school programs, and of course, your local Prop. 10 Commission. Contact us at (510) 839-1195 if you would like more information on any of these groups or ideas for working with them. ◆

Resources

Products, books, furniture and posters described in this Resources section are brought to your attention so that you can see what is available. ***Child Care Health Connections*** does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and Materials

Magic of Everyday Moments, from Zero to Three. Practical tips for parents on turning daily routines into quality baby time. Free. Available from Johnson and Johnson Pediatric Institute, (877) 565-5465 or www.zerotothree.org/magic.

Accessing Health Services: Moving Beyond Enrollment, Children's Defense Fund. Tools for reaching out to families, enrolling children in health insurance, and assisting enrolled families. www.childrensdefense.org/pdf/chip_accessinghealth.pdf.

Asthma Moms includes information in English and Spanish on managing asthma at school and controlling triggers at home. Includes resources and a discussion section: www.asthmamoms.com.

Online Resources

Joan Fleitas, EdD, RN, Associate Professor of Nursing at Fairfield University, has created "Band-Aides and Blackboards" to help people understand what it's like to grow up (and go to school or child care) with medical problems, from the perspective of the children and teens doing just that: www.faculty.fairfield.edu/fleitas/frame.html.

In collaboration with the American Academy of Pediatrics, the nation's leading medical societies have joined forces to create Medem, an e-health network. To register for their Smart Parents' Health Source Newsletter, go to www.medem.com/medlb/medlb_msphs.cfm.

Resources for Children and Current Events

The National Association of School Psychologists provides resources and information for parents and educators: www.nasponline.org.

N.Y. University Child Study Center: www.AboutOurKids.org.

The Learning Network: www.familyeducation.com.

Children Now: www.childrennow.org/television/twk-news.htm.

Purdue University Extension: www.ces.purdue.edu/terrorism/children/index.html.

San Diego State University
Child Care Health Connections
5500 Campanile Drive
San Diego, CA 92182-1874

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